FEDERAL HEALTH CARE SPENDING

HEARING

BEFORE THE

COMMITTEE ON THE BUDGET
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

HEARING HELD IN WASHINGTON, DC, FEBRUARY 17, 1993

Serial No. 103-2

Printed for the use of the Committee on the Budget

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FEDERAL HEALTH CARE SPENDING

WEDNESDAY, FEBRUARY 17, 1993

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE BUDGET,
Washington, DC.

The committee met, pursuant to notice, at 10:03 a.m., Room 210, Cannon House Office Building, Hon. Martin Olav Sabo, Chairman, presiding.

Members present: Representatives Sabo, Kildee, Wise, Bryant, Stenholm, Coyne, Andrews, Mollohan, Gordon, Price, Costello, Mink, Orton, Blackwell, Pomeroy, Kasich, McMillan, Kolbe, Snowe, Smith of Texas, Cox, Allard, Hobson, Miller, Lazio, Smith of Michigan, Inglis, and Hoke.

Chairman SABO. Good morning. The House Budget Committee is in session. This morning's hearing will be on Federal health care spending, focusing on the two largest programs, medicare and medicaid.

First, I would like to welcome back Dr. Robert Reischauer, the Director of CBO.

Health care represents a very large part of our national budget. The United States last year spent about $840 billion on health, about 14 percent of our GNP. It is projected to grow to $940 billion this year, and CBO projects that total health care spending will reach $1.7 trillion by the year 2000 and consume 18 percent of our gross domestic product. Clearly, we spend more than most countries, yet leave many people uninsured in our country.

The Federal Government pays about a quarter of our national health care bill. In 1992, we will have spent about $223 billion on a variety of programs, the two biggest being medicare, where in 1992 we spent $119 billion, and medicaid, $68 billion.

CBO cites this spending on health care as the main reason for the large Federal deficits in the 1990's. They are the fastest growing parts of the Federal budget and are the only major programs estimated to increase significantly during the rest of the decade.

We look forward to hearing from you today, Dr. Reischauer, to explain the reasons for this explosive growth in the medicare and medicaid programs, where we are going, and what the impact is on the Federal budget and Federal deficit if we don't control this explosion.

I should make it clear that our hearing today is basically analytical. It is about what has happened, and what is likely to happen in the future. It is really not focusing on alternatives for changing the total health care system, but what is happening within medicare and medicaid. So we look forward to hearing from you.

[The prepared statement of Hon. Martin Olav Sabo follows:]

PREPARED STATEMENT OF HON. MARTIN OLAV SABO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MINNESOTA

Good morning. The House Budget Committee is in session. This morning's hearing will be on Federal health care spending—focusing on the two largest programs, medicare and medicaid.

First, I would like to welcome back Dr. Robert Reischauer, the Director of the Congressional Budget Office (CBO).

For all Americans, health care spending represents a very large part of our national budget. The United States last year spent about $840 billion on health—more than 14 percent of the Nation's total economic output. The Department of Commerce, which released the latest health spending data, estimates that the U.S. will spend approximately $940 billion this year. CBO projects that total health spending will reach $1.7 trillion by the year 2000 and consume 18 percent of our gross domestic product (GDP).

The United States spends more per capita and more as a percentage of national income than any other industrialized nation, yet falls below most countries in many health indicators such as infant mortality and life expectancy. Despite billions of Federal outlays each year, more than 35 million Americans have no health insurance coverage.

The Federal Government foots more than a quarter of our current national health care bill. When all the bills are in, the Federal Government will have spent about $223 billion on health in 1992, with medicare accounting for $119 billion and medicaid $68 billion. CBO cites Federal spending on health as the main reason for the exorbitant Federal deficits in the 1990's. Medicare and medicaid are the fastest growing parts of the Federal budget and are the only major programs estimated to increase significantly during the rest of the decade. CBO estimates that the Federal deficit will exceed $500 billion by the year 2000 and $650 billion by the year 2003, largely as a result of soaring medicare and medicaid costs.

We look forward to hearing Dr. Reischauer explain the reasons for the explosive growth in medicare and medicaid, where we are going, and what may be the impact on the Federal deficit if we can't control this explosion.

The United States has the dual dilemma of soaring health care costs and lack of health care access for 16 percent of our populace. The President and Congress must deal with these troubling issues. We know that we must close the gap in health care. We also know that, if we can't control our health care costs, we can't make the deficit reduction planned by President Clinton stick. It is as simple as that. I am committed to solving these problems, and I look forward to your help, Dr. Reischauer.

Chairman SABO. Mr. Kasich, any comments?

Mr. KASICH. Thank you, Mr. Chairman, and I again want to welcome Dr. Reischauer here.

Obviously, it is a complicated area. I think sometimes we make it out to be more complicated than it is. We have got to make some hard choices, and I hope you can put us in a position over the next several weeks, Doctor, to outline what some of the real alternatives are and what some of the real choices are, in order to get things under control.

It is obviously critical that we get it under control because in order to make significant reductions in the budget deficit, we have to control medicare and medicaid. Now, the President is talking, I guess, about $35 to $40 billion in medicaid and medicare cuts that are not part of a reform package. And that may be achievable, but it will, in fact, involve cranking down the reimbursement rates to doctors, hospitals, and perhaps making some further contributions on medicare Part B, something I have supported and proposed initially about 4 years ago.

I think that is possible to do and may even be desirable, but at the same time, I think it is important to realize that those kind of

green-eyeshade games don't exlain what we need to do to reduce health care spending in the out-years. It is going to take much broader application.

I would imagine that the Democrats as well as the Republicans are going to have great difficulty in year 3 and 4 of any budget plan. It will be difficult to be specific about numbers that produce long-term savings until Mrs. Clinton, Senator Chafee and Bob Michel all have a chance to sit down and put together their long term strategy for the problem of health care costs.

But I think it is important you are here briefing a number of members here who have not had the opportunity to spend a lot of time on health care. For our side, Congressman McMillan, Congressman Hobson, and myself served for 18 months on Bob Michel's task force. It was very interesting. We learned an awful lot. And really the entire Congress and the American people have got to understand what the choices are with health care.

Again, I don't think they are that complicated, but I think it requires some guts, just like everything else we do in budgeting. So I want to welcome you here this morning.

Chairman SABO. Thank you, John.

Dr. Reischauer?

STATEMENT OF HON. ROBERT D. REISCHAUER, DIRECTOR, CONGRESSIONAL BUDGET OFFICE

Dr. REISCHAUER. Mr. Chairman, members of the committee, I appreciate the opportunity to appear before you today and discuss the effect of health care spending on the Federal budget. With your permission, I am going to submit my prepared statement for the record, and I will summarize that statement here this morning.

Health care spending is by far the most rapidly growing component of the Federal budget. It is projected to grow by more than 11 percent annually between 1993 and 1998 and will constitute nearly a quarter of Federal spending by 1998. That would be up from 13.4 percent of the budget in 1990, so we are seeing a huge increase in the relative importance of health in public spending.

Clearly, it will be difficult, if not impossible, to control Federal spending and to reduce the deficit if changes are not made in the current patterns of spending on health care. About 85 percent of health care spending in the Federal budget is for medicare or medicaid, so I will focus my remarks on those two programs.

Medicare has two components. The Hospital Insurance, or HI, component covers acute care services that are provided in hospitals, hospices, and skilled nursing facilities, and it also covers some home health care services. Hospital benefits account for about 80 percent of all HI spending, but it is the costs of the other services that are growing most rapidly. For example, while hospital spending is expected to increase by about 8 percent this year, home health spending will rise by nearly 38 percent, and spending for hospices and skilled nursing facilities will each increase by over 20 percent.

HI payments are increasing more than twice as fast as the revenues from the HI payroll tax, and beginning in 1994, payments are going to exceed revenues. This means that the $127 billion surplus,

or balance, in the HI trust fund is going to begin declining—and declining rapidly—after 1994. It will be exhausted, we estimate, sometime in the year 2001, which suggests that the Congress is not going to be able to avoid this problem. Some remedial action will be required if nothing else is done for the HI program before the turn of the century.

The second component of the medicare program is Supplementary Medical Insurance, or SMI, which pays for physician services, outpatient hospital services, and other types of ambulatory care. Over the next 5 years, spending for physician services will rise at about 13 percent a year by CBO's estimates, while spending for outpatient hospital services will grow by almost 18 percent a year.

SMI participants, as you know, must pay monthly premiums that are set to cover roughly one-quarter of the program's costs. The remainder is made up from general funds from the Treasury. After 1995, premium increases for the SMI program are going to be limited to the social security cost-of-living adjustment; in other words, we can't increase the premium rates faster than the COLA.

Since SMI costs, of course, are expected to grow one heck of a lot faster than the social security COLA, this means that under current law the drain on general revenues is going to mount rapidly. It will be a bit over $46 billion in the current year. By 1998, it would be over $91 billion. So we are facing a problem in that part of the medicare program as well.

Over the past decade, major changes have been made in the way that medicare reimburses providers for services. Retrospective cost-based reimbursement for inpatient hospital services has been replaced with a prospective payment system that pays hospitals a predetermined amount based on the patient's diagnosis, on the treatment the patient receives, and on certain characteristics of the hospital.

When this new system was introduced in 1983, it provided hospitals with incentives for efficiency that did not exist under the old cost-based reimbursement system. These incentives led to a significant slowdown in the real growth of hospital spending per enrollee. The annual increase in per-enrollee spending slowed from around 4 percent between 1983 and 1984 to less than 1 percent between 1985 and 1987, and then kicked up to about 1.5 percent between 1987 and 1991.

Because the hospital admission rate is rising again and because some fat, in a sense, has been cut out of the system, CBO expects this increase in per-enrollee real spending to bounce back up to about 5 percent a year over the next 5 years. In other words, we have achieved some savings, but it is not proper to assume that they are going to occur in the future.

A new Medicare Fee Schedule for physician services was put in place in January of last year. It replaced the payment system under which medicare's rates were set separately for each physician at the lowest of actual charges, the physician's customary charges, or the locally prevailing charge for whatever the service was.

The new fee schedule is based on something called a resource-based relative value scale. Some variation in fees is allowed to re-

flect local differences in medical practice costs—that is, the cost of running an office in Los Angeles versus in Omaha.

The fee schedule rates are updated each year based on growth in an index of practice costs. They are adjusted up or down depending on whether growth in the volume of services 2 years earlier fell below or above the target rate that Congress had set for it under the volume performance standards. CBO projects that medicare spending per enrollee on physician services will grow at about 11 percent annually over the next 5 years. It is important to realize that part of this increase is attributable to the fact that physician expenditures in 1992 came in under the volume performance standard target. Therefore, these fees will be boosted significantly starting in 1994.

The other big Federal health program is the State-administered medicaid program, which provides medical care to certain low-income people. The Federal Government pays between 50 percent and 79 percent of the program's costs, depending on the State's per capita income. States must provide medicaid coverage for some groups, such as AFDC and SSI recipients and pregnant women and children with incomes below certain thresholds. Medicaid also must pay the medicare premiums and cost sharing for certain low-income medicare beneficiaries. States also have an option to cover additional groups.

The Federal Government mandates that States provide certain benefits under medicaid, but States have the option to cover certain other specified services. In most States, medicaid provides comprehensive coverage that exceeds many private health packages, with no requirement or a very minimal requirement for cost sharing on the part of the beneficiary.

Although the program is directed at low-income people, only about half of the population with income below the poverty line was covered by medicaid in 1991. Some people who are living in poverty have private insurance provided by an employer or that they have purchased themselves, but many others are not eligible for medicaid and therefore are uninsured. If all of the uninsured people below the poverty level had been eligible for medicaid in 1991, about 10 million more people would have been covered by the program.

Total medicaid expenditures reached $119 billion in 1992. About 57 percent of that amount represented Federal spending, and the balance represented contributions by the States.

In recent years, medicaid spending has been exploding. From 1989 to 1991, total medicaid spending grew at an annual pace of about 23 percent, and in 1992 the rate was 29 percent. CBO expects medicaid spending to grow by about 18 percent this year and then to slow down to about 13 percent between 1993 and 1998.

The unprecedented pace of recent medicaid growth has stemmed mainly from three factors. First, enrollment has risen, largely because of the weak economy and because legislation has expanded eligibility, and States have also increased their efforts to enroll low-income pregnant women and children. Second, medical prices have increased significantly, which has had a big effect. And third, in 1991 and 1992, in particular, States dramatically expanded their use of various financing mechanisms that allowed them to boost

the Federal Government's matching payments to them. They did this as a response to the fiscal stress that they were under.

More than two-thirds of medicaid's beneficiaries are low-income children and adults, and that is the way most Americans view this program. But from a financial standpoint, it is a very misleading impression because 70 percent of medicaid payments are made on behalf of the 30 percent of medicaid beneficiaries who are aged or disabled. In other words, most of the bucks are being spent for aged and disabled people, not low-income mothers and children.

A significant portion of this spending, of course, is for long-term care, which is not covered by the medicare program. Nearly 40 percent of medicaid payments in 1991 were for nursing home services. So keep in mind that this program has a very, very large component that pays for nursing home care for disabled and elderly individuals.

Because they face burgeoning medicaid costs and pressures to increase their reimbursement rates, States have turned increasingly to voluntary donations and taxes on health care providers to finance their share of medicaid's expenditures. These devices can generate additional Federal matching dollars without corresponding expenditures of State funds. Estimates suggest that these schemes cost the Federal Government almost $3.8 billion in 1991 and probably more than that in 1992. In November 1991, Congress enacted legislation that places some restrictions on the use of provider donations and taxes, so that situation is not getting worse and is probably improving modestly.

Some hard-pressed States have also used the flexibility that is allowed them under medicaid's disproportionate share adjustment for fiscal relief. Disproportionate share adjustments are payments to institutions that serve disproportionately large numbers of low-income patients. Recent legislation has capped these payments at 12 percent of medicaid expenditures, both in the State and nationally. But various States were grandfathered at a higher level. Therefore, it is going to be a few years before the disproportionate share payments for other States can rise to 12 percent.

Let me conclude by saying a few words about the inexorable link between Federal spending for health care and overall health care spending. This, in a way, is relevant to some of the suggestions that Mr. Kasich was mentioning.

In a complex multipayer system such as ours, it is impossible to constrain costs by one payer without having a profound impact on other payers because cost shifting occurs. Nowhere is this more clearly illustrated than in the area of hospital costs.

Year in and year out, medicaid's reimbursements for hospital services have been lower than hospitals' costs. In other words, we have been buying medicaid services from hospitals on the cheap. In 1990, reimbursement was estimated to average only about 80 percent of the costs incurred by the hospital for the service rendered.

The situation was quite different in medicare, where, after we introduced the prospective payment system, reimbursement rates were considerably higher than the costs of the hospital. But over the last half of the 1980's, we restrained the increase in these reimbursements significantly, to the point that now medicare payments

are estimated to cover just 90 percent of the costs that hospitals incur for medicare patients.

While these public-sector payment rates might be heralded as representing a great saving to the taxpayer, such a conclusion would be naive, because what taxpayers have saved in direct tax payments they have had to fork over indirectly.

Payments to hospitals from private insurance payers exceed the cost of treating those patients by about 28 percent. In other words, the charges that are received from Blue Cross/Blue Shield or Prudential or whomever are in excess of the cost of the services delivered to their patients so that hospitals can make up for the loss that they incur with respect to medicare and medicaid patients.

Thus, what taxpayers have saved in taxes they have made up for in higher premiums for employment-based and individual policies. So, in the aggregate, there probably has been no saving. This suggests that efforts to control the explosion of Federal health care costs must have a systemic focus. They must look beyond the borders of medicare and medicaid.

While this makes the task more difficult, the need to curb the rate of growth in health care spending is obvious. It will be difficult, as I said at the beginning, to bring the deficit under control if health care spending continues to run amok; furthermore, the ranks of the uninsured will grow if we let health care costs rise so rapidly. Health coverage will be unaffordable to more and more individuals and more and more companies. And you will see the growth of cash wages curbed because more of compensation will be diverted to pay for increased benefit costs that the employer must bear. And so the time is now. This is, as Mr. Kasich said, an extremely difficult issue to grapple with, but it is good to see that this committee is focusing on the issue.

I will be glad to answer any questions the committee has.

[The prepared statement of Dr. Robert D. Reischauer follows:]

PREPARED STATEMENT OF HON. ROBERT D. REISCHAUER, DIRECTOR, CONGRESSIONAL BUDGET OFFICE

Mr. Chairman, I appreciate the opportunity to testify before the committee on the effect of health care spending on the Federal deficit. I will also provide more detailed information on the medicare and medicaid programs and the factors that are causing spending for these programs to rise so swiftly. Finally, my testimony will examine the relationship between Federal and overall spending for health care in the United States.

HEALTH CARE SPENDING AND THE FEDERAL BUDGET

Over the next five years, the Federal budget deficit is projected to increase, and the major factor driving that growth is entitlement programs for health care. Spending on health was 13.4 percent of the Federal budget in 1990 will be approximately 17.5 percent in 1993, and the Congressional Budget Office (CBO) projects that health expenditures will account for nearly one-quarter of the budget by 1998 (see Table 1).

Health care is by far the most rapidly growing component of the Federal budget. In fact, every other major component of the Federal budget is either declining or growing more slowly. CBO projects that growth in spending on health within the Federal budget will average more than 11 percent a year between 1993 and 1998. This growth rate, which represents more than 8 percent after adjusting for projected inflation, is considerably higher than that projected for other components of the budget (see Figure 1). Net interest and social security are projected to increase at inflation-adjusted annual rates of about 5 percent and 2 percent, respectively. The other components of the Federal budget are projected to decline.

Clearly, controlling Federal spending and reducing the budget deficit will be extremely difficult—if not impossible—if no change takes place in current patterns of spending on health care. Since about 85 percent of Federal spending on health is for medicare and medicaid—and they are growing much more rapidly than any other health programs—this testimony will concentrate primarily on these two entitlement programs.

THE MEDICARE PROGRAM

Medicare was enacted in 1965 and put into place in July 1966. The program was designed to ensure that older Americans would have access to health care after they were no longer working. Anyone who is age 65 and eligible for social security benefits is automatically eligible for Hospital Insurance (HI), which covers acute care services provided in hospitals, hospices, and skilled nursing facilities, as well as some home health care. Supplementary Medical Insurance (SMI), which covers physician services, outpatient hospital services, and other ambulatory care, covers individuals who are at least 65 and elect to participate in the program. In addition to the aged, many people who are severely disabled or who have end-stage renal disease are eligible for medicare, under provisions enacted in 1972 that extended the program.

In 1993, approximately 31.5 million people age 65 and older and 3.5 million disabled people are covered under the HI program. About 31 million aged and 3.2 million disabled people are enrolled in SMI. The number of medicare enrollees is projected to increase about 2 percent a year over the next five years.

Because medicare is available to nearly all people age 65 or older, only about 300,000 elderly people were uninsured in 1992. Thus, the medicare program accomplishes its intended objective—to extend access to health care to older Americans.

Although nearly every worker has contributed to the HI trust fund, current medicare enrollees receive a substantial subsidy under that program. CBO estimates that for the cohort of people who became 65 in 1992, medicare will pay at least 60 percent more per person for HI benefits over their lifetimes than the value of their contributions and those made by their employers. In 1992 dollars, this amount represents an annual subsidy of about $2,000 per enrollee. In addition to the HI subsidy, those enrolled in the SMI program pay only about one-quarter of the costs of the benefits they receive under SMI.

Spending for Medicare

HI spending is estimated to be about $91 billion in 1993, rising to almost $149 billion in 1998. Although hospital benefits account for more than 80 percent of HI spending, the costs of other services have risen much more dramatically in the past year—for example, hospital spending is estimated to have increased about 8 percent between fiscal year 1992 and fiscal year 1993 compared with nearly 38 percent for home health care, 22 percent for hospice care, and 28 percent for skilled nursing facility care. After adjusting for inflation, hospital spending growth was estimated to be nearly 5 percent, with home health care, hospice care, and skilled nursing facility care growing about 34 percent, 18 percent, and 25 percent, respectively. The reasons for such rapid growth vary and are not fully understood. CBO's projections assume that it will not continue over the 1993–1998 period.

During the 1993–1998 period, HI payments are projected to increase more than twice as fast as revenues, however, and beginning in 1994 they will exceed revenues from the HI payroll tax (2.9 percent on earnings up to $134,700 in 1993). In fact, the $127 billion projected balance in the HI trust fund at the end of 1993 will decline rapidly, and the trust fund is expected to be exhausted during 2001.

Overall SMI spending—including the portion paid by enrollees' premiums—is projected to increase from $58 billion in 1993 to $113 billion in 1998. Spending for physician services—which accounts for about 54 percent of SMI—is projected to rise at an average annual rate of nearly 13 percent over the 1993–1998 period, and spending for outpatient hospital services—which accounts for 21 percent of SMI—is projected to grow an average of nearly 18 percent annually. After adjusting for projected inflation over the 1993–1998 period, physician and outpatient spending are expected to rise about 10 percent and 14 percent a year, respectively.

The premium paid by those voluntarily enrolled in SMI—$36.60 per month in 1993—is set by law at a level intended to cover 25 percent of the program's cost through 1995. In 1996 and beyond, increases in premiums are limited to the percentage increase in the social security cost-of-living adjustments. The remaining financing comes from general tax revenues. In 1993, more than $46 billion in general revenues will be necessary; by 1998, that amount is projected to reach $91 billion.

Medicare's Payment System for Hospitals

In the Social Security Amendments of 1983, the Congress replaced retrospective, cost-based reimbursement for inpatient hospital services provided to medicare beneficiaries with the prospective payment system (PPS). Under this system, hospitals are paid a predetermined amount for each medicare patient, based on the patient's diagnosis and treatment and on certain characteristics of the hospital. If the expenses associated with treating the patient are less than the payment, the hospital can keep the surplus. If the cost exceeds the payment, however, then the hospital incurs a loss.

The payment rates used by the PPS reflect the variations in costs among hospitals that result from factors considered to be beyond the hospital's control and not related to its efficiency. Payments are therefore adjusted for certain cost-related factors, such as labor costs in the local area. The PPS currently applies separate rates to hospitals in large urban areas (those with populations of more than 1 million), other urban areas, and rural areas. The difference in rates between other urban areas and rural areas is gradually being phased out, however, and will be eliminated by 1995.

The PPS provided hospitals with incentives for efficiency that did not exist under the previous cost-reimbursement system. Following the introduction of the PPS, the growth rate in inflation-adjusted spending for hospital care per enrollee dropped rapidly, from an increase of around 4 percent between 1983 and 1984 to less than 1 percent annually between 1985 and 1987. Growth has been somewhat higher since then—about 1.5 percent annually between 1987 and 1991, after adjusting for inflation.

CBO's projections for the 1993–1998 period indicate that hospital spending will rise at an average annual rate of nearly 8 percent per enrollee in nominal terms, and 5 percent per enrollee after adjusting for inflation. This higher growth is expected, in part, because medicare admissions to hospitals are rising. In addition, PPS rates were initially set at a level that exceeded hospitals' average costs per case, partly as a result of an error in the methodology. Consequently, for several years, updates to the payment levels were held below the level that would have been justified by increases in hospitals' costs. For the 1993–1998 period, however, increases in payment levels to cover the rise in hospitals' costs are projected.

Medicare's Payment System for Physicians

Based on legislation enacted in 1989, the new Medicare Fee Schedule (MFS) for physician services was put in place on January 1, 1992. The MFS replaced a payment system under which medicare's rates were set separately for each physician at the lowest of the actual charge, the physician's customary charge, or the locally prevailing charge for that service.

The new fee schedule reflects a resource-based relative value scale developed by a research group at Harvard University in consultation with the Health Care Financing Administration (HCFA) and the Physician Payment Review Commission (PPRC). The value of each procedure is ranked relative to all other procedures and is uniform for all specialties. The resulting fees, however, vary among 233 payment localities based on a geographic index of medical practice costs.

Overall payment rates under the MFS were 6.5 percent lower in 1992 than they would otherwise have been, although according to HCFA's estimates, total payments to physicians were to be unchanged as required by the legislation. HCFA's calculation assumed that an increase in the volume of services would occur as a result of the MFS, making a reduction in the payment rates necessary to achieve budget neutrality.

The MFS rates are updated each year based on growth in an index of practice costs (the Medicare Economic Index). These rates are adjusted up or down depending on whether growth in the volume of services two years earlier fell below or above a target rate for growth in expenditures set by medicare's volume performance standard (VPS). The Congress sets the VPS, based on recommendations from the Department of Health and Human Services and PPRC. If the Congress fails to act, the VPS is set by a default formula that reflects payment rates, growth in enrollment, and the volume of services per enrollee; adjustments are made to reflect the effects of any enacted legislation.

Medicare spending for physician services grew at an inflation-adjusted rate of 8 percent per enrollee annually between 1980 and 1985 and 5.6 percent annually between 1985 and 1991. CBO's projections for the 1993–1998 period suggest that medicare's spending for physician services will continue to grow rapidly, by about 11 percent annually per enrollee averaged over that period, in nominal terms, and by more than 8 percent annually after adjusting for inflation. This higher growth rate

occurs in part because the 1992 physician expenditures came in under the VPS targets. As a result, physicians will receive a significant increase in fees in 1994.

THE MEDICAID PROGRAM

Medicaid is the state-administered program that, since 1966, has operated under Federal guidelines to provide medical care to certain low-income people. Federal and state governments jointly fund the program with Federal financial participation rates that currently range from 50 percent to 79 percent, based on a formula that takes into account the ability of the state to finance the program. The states have considerable discretion in establishing the criteria on income and assets for program eligibility; setting the amount, duration, and scope of covered services; and determining methods for reimbursing providers.

Elibility

Under Federal rules, states are required to provide medicaid coverage for some groups of the population and may cover additional groups for which they also receive Federal matching funds. Recipients of Aid to Families with Dependent Children (AFDC) are entitled to medicaid benefits, as, in general, are recipients of Supplemental Security Income (SSI). Thus, changes in AFDC or SSI enrollment also affect the number of medicaid beneficiaries. (In the context of the medicaid program, the term "beneficiaries" denotes people who receive services paid for by medicaid.) More than 60 percent of medicaid beneficiaries receive cash assistance from AFDC or SSI and are considered to be "categorically needy."

The remaining 40 percent of medicaid beneficiaries include other low income people who are aged, blind, disabled, or members of families with dependent children, plus other low-income children and pregnant women. Some of these groups are also considered to be categorically needy. They include potential recipients of AFDC and SSI, plus pregnant women and children entitled to coverage under the recently legislated expansions. Others are medically needy; that is, they meet the nonfinancial criteria for categorical eligibility and become eligible for medicaid when, after subtracting their incurred medical expenses, their income and resources fall below limits set by the state. In addition, some elderly and disabled beneficiaries have partial medicaid protection in the form of assistance that pays for medicare's premiums and cost sharing.

The proportion of medicaid beneficiaries who do not receive cash grants has grown as legislation in recent years has loosened the link between medicaid and cash assistance, especially for low-income children and pregnant women. The most recent expansion of benefits eventually will cover all children under age 19 in families with income below the Federal poverty level. This expansion is being phased in, with children up to age nine now covered, and will not be fully completed until 2002. States are now also required to pay medicare premiums and cost sharing for medicare beneficiaries with income below the poverty level and resources less than twice the asset level for SSI. Further coverage of low-income medicare beneficiaries is also being phased in. Commencing in January 1993, states must pay SMI premiums for medicare beneficiaries with income less than 110 percent of the poverty level and resources less than twice the SSI asset level; the income criterion for eligibility will be raised to 120 percent of the poverty level in 1995.

Benefits

The Federal Government mandates some benefits under medicaid, with states having the option to cover other specified services. Mandatory benefits for the categorically needy include hospital services; physician services; laboratory and X-ray services; family planning services; nursing facility (NF) services for people over age 21; home health care for people entitled to NF services; Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program services for people under 21 years old; services provided by rural health clinics and federally qualified health centers; and the services of nurse midwives, certified pediatric nurse practitioners, and certified family nurse practitioners (in states in which those providers are authorized to practice).

Mandatory services for the medically needy population are less comprehensive than the benefits that must be provided to the categorically needy. At a minimum, however, states with programs for the medically needy must provide ambulatory care for children and prenatal and delivery services for pregnant women.

States may, at their option, provide additional services. In October 1991, most states chose to offer at least the following services to categorically needy people: podiatry; optometry; clinic services; dental services; physical therapy; services for people with speech, hearing, and language disorders; transportation; intermediate

care facility services for the mentally retarded (ICF-MR); nursing facility services for people under 21 years old; rehabilitative services; prescription drugs; inpatient hospital services for elderly people in mental institutions; emergency hospital services; case management; prosthetic devices; and eyeglasses. Some states offered several additional services. Thus, in most states, medicaid provides comprehensive coverage that exceeds many private health insurance packages, with no requirements (or minimal requirements) for cost sharing on the part of beneficiaries.

Medicaid and Poverty

Despite the increasing number of people eligible for the medicaid program, only about half of the population with income at or below the poverty level was covered by medicaid in 1991. Some of those who are living in poverty have private insurance through employment or another source. Many, however, are not eligible for medicaid and are uninsured. If all uninsured people below the poverty level had been eligible in 1991, about 10 million more people would have been covered by medicaid. Expanding medicaid eligibility to include all children under age 19 in families with income below the Federal poverty level by 2002 will lower the number of uninsured poor people, but a substantial number of uninsured low-income adults will remain ineligible for medicaid.

Medicaid Spending

Medicaid expenditures have grown dramatically in recent years, reaching $119 billion in 1992. Federal spending made up 57 percent of this amount, with state and local spending accounting for the balance. Total medicaid spending includes both payments for services provided directly to beneficiaries and other costs. Payments for services provided to medicaid beneficiaries were about 90 percent of total medicaid spending throughout most of the 1980's. By 1991, however, payments for services had dropped to 83 percent of total spending, reflecting in part changes in the financing of the program that are discussed below.

After adjusting for inflation, the average annual rate of growth in total medicaid spending from 1980 to 1989 was about 5 percent a year. From 1989 through 1991, however, real growth averaged almost 17 percent and rose a further 25 percent in 1992.

That unprecedented growth stemmed mainly from three factors. First, enrollment rose rapidly, largely because of the weak economy, legislation expanding eligibility for the medicaid program, and subsequent efforts by states to enroll low-income pregnant women and infants. Second, medical prices increased significantly in 1990 and 1991. Third, in 1991 and 1992, states dramatically expanded their use of financing mechanisms that enabled them to boost the Federal Government's matching payments.

Spending by Eligibility Group.—In 1991, there were 28 million medicaid beneficiaries—19.5 million children and adults in low-income families, 3.3 million people 65 years of age and older, 4 million disabled people, and about 1 million others. Thus, more than two-thirds of medicaid beneficiaries are low-income children and adults (see Table 2).

Spending under medicaid for services provided directly to beneficiaries, however, goes disproportionately to the aged and disabled populations. Although these groups represented only 30 percent of the medicaid population, they accounted for 70 percent of total payments in 1991. Average medicaid payments for aged beneficiaries were $7,600; for disabled beneficiaries, payments were $7,000. In contrast, low-income children and adults incurred average costs of $900 and $1,600, respectively.

One reason that medicaid spending is so high for aged and disabled beneficiaries is that medicaid, unlike medicare, pays for long-term care. The average payment per user of ICF-MR nursing home services in 1991 was $52,600; for medicaid beneficiaries who used other nursing home services, the average payment was lower but was still $13,800 in that year. Moreover, those amounts do not include the other services used by nursing home residents for which medicaid paid. Nearly 40 percent of medicaid payments in 1991 were for nursing home services.

Voluntary Donations and Taxes on Health Care Providers.—Faced with burgeoning medicaid costs and pressures to increase their reimbursement rates, states turned increasingly to voluntary donations and taxes on health care providers (primarily hospitals and nursing homes) to finance their share of medicaid expenditures. Through the use of these devices, states could generate additional Federal matching dollars without corresponding expenditures of state funds, thereby raising the overall Federal matching rate from its nominal level of 57 percent. By July 1991, the majority of states had adopted donation or provider-specific tax programs, and the Department of Health and Human Services was concerned that these initiatives were threatening the financial stability of medicaid.

The Inspector General estimated that provider donation and tax programs would cost the Federal Government almost $3.8 billion in fiscal year 1991, and that the figure could rise to $12.1 billion in fiscal year 1993. In October 1991, therefore, HCFA issued interim final regulations to restrict Federal matching for state medicaid expenditures financed through voluntary donations or taxes on health care providers.

By effectively eliminating provider donation and tax programs, the HCFA regulations would probably have compounded the severe fiscal problems many states faced. In November 1991, therefore, the Congress enacted legislation to nullify the HCFA regulations and also to place some restrictions on the use of provider donations and taxes. The act, titled the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, represents a compromise by the administration, the Congress, and the states. It bars Federal matching for most provider donations but allows the states to use intergovernmental transfers and some types of tax revenues from providers to finance part of their share of the medicaid program.

Payments to Disproportionate Share Hospitals.—The act also has important implications for medicaid's reimbursement of disproportionate share hospitals, those institutions that serve disproportionately large numbers of low-income patients with special needs. When setting medicaid hospital payment rates, states are required to take the costs incurred by disproportionate share hospitals into account. The Congress has established minimum criteria for defining these hospitals and for determining the rates at which they must be paid.

States may, however, use alternative methods to define disproportionate share hospitals and to set the additional payment amounts they receive, provided the total payment adjustment is at least as great as under the statutory options. Some states have taken advantage of this flexibility to increase their payments to disproportionate share hospitals dramatically in the last two years. Furthermore, they have frequently used voluntary donations and taxes on health care providers to pay all or part of their share. HCFA issued regulations limiting such payments in October 1991, but the Congress also nullified those regulations.

Instead, the November 1991 legislation creates a national cap on payment adjustments to disproportionate share hospitals of 12 percent of medicaid expenditures. States whose disproportionate share payments are already above this cap can continue to make payments at the higher level but cannot increase them until they fall below the 12 percent cap. As national medicaid expenditures rise, states that are below the 12 percent cap will be allowed to increase their disproportionate share payments using a redistributive approach that ensures that the national cap remains at 12 percent. In addition, the act bars HCFA from restricting a state's authority to designate disproportionate share hospitals. In November 1992, HCFA published an interim final rule carrying out the 1991 legislation. According to that rule, all disproportionate share allotments to states for fiscal year 1993 would be frozen at their 1992 amounts because total disproportionate share payments were already at the 12 percent level.

Projections of Medicaid Spending.—CBO estimates that medicaid spending will grow by about 18 percent in 1993, to more than $140 billion, of which the Federal Government will pay about $80 billion. This estimate represents an annual increase of 15 percent after adjusting for inflation. The annual rate of growth will be somewhat lower between 1993 and 1998, averaging about 13 percent in nominal terms or about 10 percent after adjusting for inflation.

Growth in medicaid spending over the next five years will primarily be the result of increased spending per beneficiary rather than the larger number of people who are eligible for medicaid. CBO projects that, on average, the number of beneficiaries will grow by 2 percent to 3 percent a year between 1993 and 1998. Total spending per beneficiary, which includes payments for services, costs of administration, and other non-service-related spending, however, is projected to increase at an average annual rate of almost 10 percent in nominal terms, or 7 percent after adjusting for inflation.

The factors contributing to such rapid growth include increases in medical care prices that exceed general inflation and changes in the number and complexity of services provided to the medicaid population. In addition, as a result of recent and pending judicial decisions interpreting medicaid statutes, states are facing growing pressures to increase reimbursement rates for institutional providers and physicians.

FEDERAL AND OVERALL SPENDING FOR HEALTH CARE

Private spending and payments by public programs for health care are interdependent, since policies designed to constrain costs by one payer often have profound implications for the level and rate of growth of spending by other payers. Without concurrent and uniform policies that affect the entire health sector, whatever is done to control Federal spending for health care would almost certainly result in higher spending by private payers. Moreover, if enacted in isolation, policies to extend coverage to the uninsured would increase health spending, most likely both at the national level and within the Federal budget.

In 1991, national health expenditures were $752 billion, accounting for more than 13 percent of the gross domestic product (GDP). CBO's revised winter 1993 projections of national health expenditures indicate that, by 2000, the United States will spend nearly 19 percent of GDP on health care under current policies. The Federal Government's share of spending is projected to rise from about 30 percent in 1991 to 36 percent in 2000.

In addition to its direct spending for health care, the Federal Government also provides a substantial subsidy for private employment-based health insurance because payments by employers are excluded from employees' income that is subject to Federal taxation. Both income and payroll taxes are lower because of this exclusion—by a total of $70 billion in 1991—although higher payroll taxes would be offset by higher social security payments in future years.

Even though there have been numerous and intensive efforts over the past two decades to control the growth in health expenditures, inflation adjusted spending per person in the Nation has continued to rise. Between 1980 and 1985, spending per person in the Nation increased at an average annual rate of 4.2 percent; between 1985 and 1991, this rate increased to 4.8 percent annually, as shown in Figure 2.

The trends for medicaid and medicare spending per person are different from the trend in total health spending. After adjusting for inflation, total medicaid expenditures per beneficiary grew at an annual rate of about 4 percent between 1980 and 1985, which was somewhat lower than the rate of growth of national health expenditures per person. Between 1985 and 1991, however, medicaid expenditures per beneficiary grew at an average annual inflation-adjusted rate of almost 7 percent. This growth primarily reflected the large 1991 increase in program costs that were not related to the direct provision of services.

Over most of the years that medicare has been operating, spending per enrollee grew more rapidly, after adjusting for inflation, than did spending per person in the Nation. Between 1980 and 1985, inflation-adjusted spending per enrollee grew about 6.1 percent a year, considerably higher than the 4.2 percent annual increase in per capita national spending. The medicare per enrollee growth rate dropped significantly over the 1985–1991 period to slightly more than 3 percent annually—which is considerably lower than the rate for per capita national health expenditures. Most of the decline in the growth per enrollee of medicare spending stemmed from a substantial drop in the rate of increase in medicare's spending for inpatient hospital services (see Figure 3).

This pattern illustrates a major factor in this country's inability to gain better control over total health spending. In a multiple-payer system, successful efforts by one payer to reduce the growth in costs—such as medicare's prospective payment system for hospitals in the mid-1980's—appear to be offset by more rapid increases in costs for other payers.

Preliminary results from a CBO study that is under way depict these interrelationships vividly. In 1990, hospitals provided $12 billion in uncompensated care and received payments that were only 80 percent of estimated costs for medicaid enrollees and 90 percent of estimated costs for medicare enrollees (see Table 3). Uncompensated care and unreimbursed public program costs totaled $25 billion, or 12 percent of hospitals' total costs.

Most hospitals, however, were able to recover the bulk of these unreimbursed costs through three mechanisms: subsidies from state and local governments, other nonpatient-care sources of revenues, and surplus revenues (or profits) from private payers. In fact, CBO estimates that in 1989 hospitals recovered about 95 percent of their uncompensated care and unreimbursed public program costs. Surplus revenues from private payers accounted for more than 50 percent of this recovery.

In 1990, the ratio of revenues to costs for private payers was 1.28—in other words, the payments to hospitals from private payers exceeded the costs of treating those patients by about 28 percent. Moreover, private payers were charged substantially

more than their costs in spite of the many efforts of private payers to control hospital spending over the same period.

CONCLUSION

Health care costs are increasing far more rapidly than inflation and show no signs of abating despite the many attempts to control costs made by both public and private payers. CBO projects that, by 1998, more than 17 percent of GDP will be absorbed by spending on health and nearly 24 percent of the Federal budget will be spent on health programs under current policies. Without a reduction in the rate of growth in health care spending, cutting the Federal budget deficit will be extremely difficult.

Other consequences of the continued rise in health spending are also of concern. Not only would more people be uninsured, but new policies to extend coverage to the uninsured would increase health expenditures even more. In addition, further growth in health insurance premiums would mean that workers would receive smaller increases in wages and salaries as more of their compensation came in the form of health insurance.

Addressing the problems of the Nation's health care system is a formidable task. If we control only Federal spending, then spending by the private sector will almost certainly increase more rapidly. But greater control over total health spending would probably mean less spending on research and development, longer waiting times for use of some technologies, and some limits on existing choices of providers, health care coverage, and alternatives for treatment. Finally, unless efforts to reduce health spending were combined with new policies to cover the uninsured, success in controlling health care costs would almost certainly create additional barriers to access for the uninsured.

TABLE 1. FEDERAL SPENDING ON HEALTH, FISCAL YEARS 1965-1998

	1965	1970	1975	1980	1985	1990	1991	1992	1993	1994	1995	1996	1997	1998
In Billions of Dollars														
Total Federal Spending	118.2	195.6	332.3	590.9	946.3	1,251.7	1,323.0	1,381.9	1,452.9	1,506.8	1,574.5	1,642.8	1,733.0	1,839.1
Federal Health Spending	3.1	13.9	29.5	61.8	108.9	168.0	188.6	222.7	254.2	286.1	320.2	355.5	393.2	434.2
Medicare	n.a.	6.2	12.9	32.1	65.8	98.1	104.5	119.0	134.1	152.3	171.7	192.7	215.3	239.3
Medicaid	0.3	2.7	6.8	14.0	22.7	41.1	52.5	67.8	80.3	91.9	105.0	117.7	131.0	145.9
Veterans Affairs	1.3	1.8	3.7	6.5	9.5	12.1	12.9	14.1	14.9	15.7	16.2	16.7	17.2	18.0
Other	1.5	3.2	6.1	9.2	10.9	16.6	18.7	21.8	24.9	26.2	27.3	28.4	29.7	31.0
As a Percentage of Total Federal Spending														
Federal Health Spending	2.6	7.1	8.9	10.5	11.5	13.4	14.3	16.1	17.5	19.0	20.3	21.6	22.7	23.6
As a Percentage of Federal Spending on Health														
Federal Health Spending	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Medicare	n.a.	44.6	43.7	51.9	60.4	58.4	55.4	53.4	52.7	53.2	53.6	54.2	54.8	55.1
Medicaid	9.7	19.4	23.1	22.7	20.8	24.5	27.8	30.4	31.6	32.1	32.8	33.1	33.3	33.6
Veterans Affairs	41.9	12.9	12.5	10.5	8.7	7.2	6.8	6.3	5.9	5.5	5.1	4.7	4.4	4.1
Other	48.4	23.0	20.7	14.9	10.0	9.9	9.9	9.8	9.8	9.2	8.5	8.0	7.5	7.1

SOURCE: Congressional Budget Office calculations and projections, January 1993.

NOTES: Medicare expenditures are shown net of premium income from beneficiaries.
"Other" includes federal employee and annuitant health benefits, as well as other health services and research.
"Federal health spending" excludes spending for the military's CHAMPUS program.

Spending for discretionary programs in the 1993-1998 period is increased each year to reflect projected inflation, starting from the 1993 appropriated levels. Although CBO's projections of total federal spending assume compliance with the discretionary spending limits for the 1993-1995 period, the Budget Enforcement Act does not specify programmatic changes to achieve those limits. Thus, it is not possible to adjust projections for individual programs to reflect the overall limits.

Details may not add to totals because of rounding. n.a. = not applicable.

TABLE 2. MEDICAID BENEFICIARIES AND PAYMENTS ADJUSTED FOR INFLATION, BY ELIGIBILITY GROUP, SELECTED FISCAL YEARS[a]

Eligibility Group	1975	1981	1988	1990	1991
All[b]					
Payments	30.5	41.7	56.3	68.1	76.9
Beneficiaries	22.0	22.0	22.9	25.3	27.9
Payment per beneficiary[c]	1,400	1,900	2,500	2,700	2,800
Aged					
Payments	10.9	15.2	19.8	22.6	25.4
Beneficiaries	3.6	3.4	3.2	3.2	3.3
Payment per beneficiary[c]	3,000	4,500	6,300	7,100	7,600
Disabled[d]					
Payments	7.8	14.5	21.5	25.6	28.2
Beneficiaries	2.5	3.1	3.5	3.7	4.0
Payment per beneficiary[c]	3,200	4,700	6,200	6,900	7,000
Children in Low-Income Families					
Payments	5.4	5.4	6.8	9.6	11.6
Beneficiaries	9.6	9.6	10.0	11.2	12.8
Payment per beneficiary[c]	600	600	700	900	900
Adults in Low-Income Families					
Payments	5.1	5.8	6.8	9.0	10.4
Beneficiaries	4.5	5.2	5.5	6.0	6.7
Payment per beneficiary[c]	1,100	1,100	1,200	1,500	1,600
Other					
Payments	1.2	0.8	1.4	1.1	1.2
Beneficiaries	1.8	1.4	1.3	1.0	1.0
Payment per beneficiary[b]	700	600	1,000	1,100	1,200

SOURCE: Congressional Budget Office calculations based on data for selected years from the HCFA Form-2082, "Statistical Report on Medical Care: Eligibles, Recipients, Payments, and Services," compiled by the Health Care Financing Administration.

NOTES: Payments are in 1991 dollars, calculated using the consumer price index for all urban consumers (CPI-U). The HCFA Form-2082 Medicaid payment amounts are based on all claims adjudicated or paid during the fiscal year covered by the report. They do not include all Medicaid expenditures. Excluded are HI and SMI premiums that states paid for the dually enrolled, premiums for capitation plans, payments for state-only enrollees and services, program administration and training costs, and other adjustments that are part of total spending.

Beneficiaries include all people who had services paid for by Medicaid during the fiscal year. Because double counting occurred in some states in the 1980s, the sum of beneficiaries in all eligibility groups exceeds the (unduplicated) total in 1981 and 1988. See "Factors Contributing to the Growth of the Medicaid Program," CBO Staff Memorandum (May 1992) for a more detailed discussion of reporting inconsistencies.

The table is based on payments and beneficiary counts from 49 states, the District of Columbia, and Puerto Rico. The state of Arizona is not included.

a. Payments in billions of 1991 dollars; number of beneficiaries in millions; and payment per beneficiary in 1991 dollars.
b. Includes beneficiaries whose eligibility group is unknown.
c. Rounded to the nearest $100.
d. Includes the blind.

TABLE 3. HOSPITAL REVENUES AND COSTS, BY PAYER OR OTHER SOURCE, 1990

Payer or Other Source	Revenues		Costs		Ratio of Revenues to Costs
	In Billions of Dollars	As a Percentage of Total	In Billions of Dollars	As a Percentage of Total	
Total	210.6	100.0	203.2	100.0	1.04
Medicare	69.8	33.2	78.0	38.4	0.90
Medicaid	18.4	8.7	23.0	11.3	0.80
Other Government Payers	3.4	1.6	3.2	1.6	1.06
Uncompensated Care[a]	2.5	1.2	12.1	5.9	0.21
Private Payers	104.1	49.5	81.6	40.1	1.28
Nonpatient Sources[b]	12.4	5.8	5.5	2.7	2.25

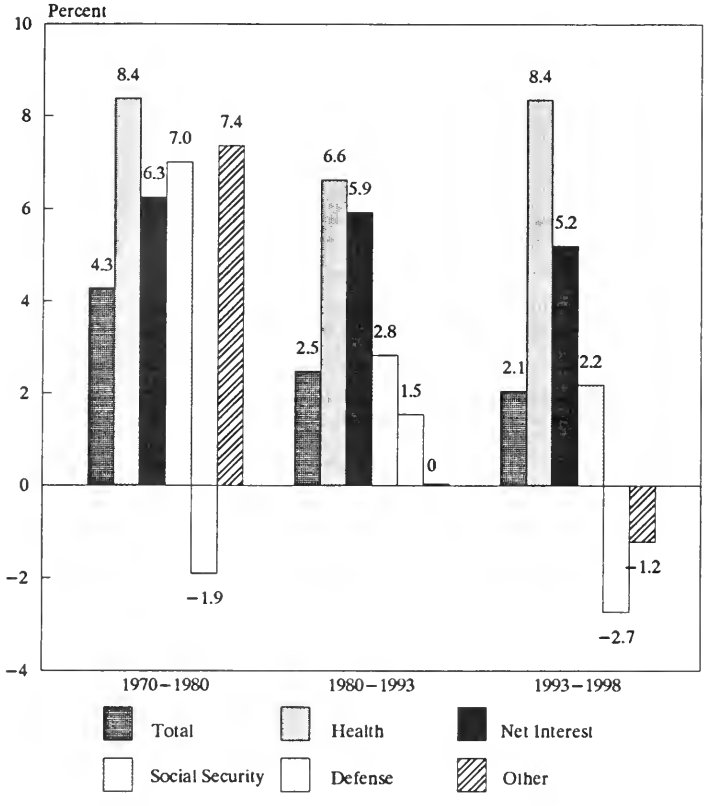
SOURCE: Congressional Budget Office estimates using data from Prospective Payment Assessment Commission, *Medicare and the American Health Care System: Report to the Congress* (June 1992).

NOTE: The underlying data are from the American Hospital Association's *Annual Survey of Hospitals for 1990*. They correspond to hospitals' fiscal years ending during calendar year 1990.

a. Uncompensated care is defined as charity care plus bad debt. The revenues shown are operating subsidies from state and local governments.

b. Includes operating revenues and costs from sources other than patient care, such as profits from cafeterias and gift shops, plus nonoperating revenues such as contributions, grants, and earnings on endowments.

Figure 1.
Average Annual Growth Rates of Real Federal Outlays, Selected Components, 1970–1998



SOURCE: Congressional Budget Office calculations, January 1993, based on actual outlays in 1970 and 1980 and projections of federal outlays for 1993 through 1998.

NOTES: The word "real" is used here to mean adjusted for general inflation rather than for inflation in the prices of health services, which is almost certainly different. Outlays are adjusted to 1991 dollars using the consumer price index for all urban consumers (CPI–U).

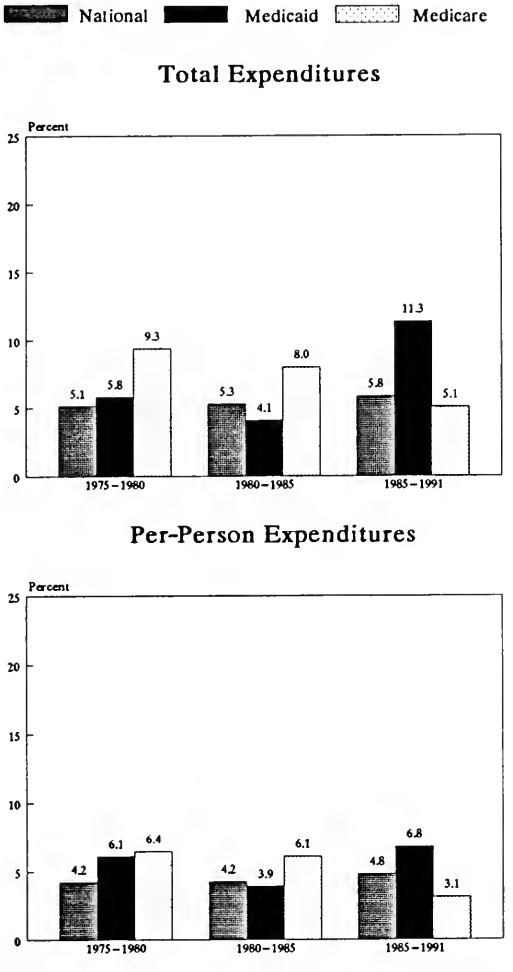
Years are fiscal years.

Health care outlays exclude those in the Department of Defense.

The "Other" category includes, for example, spending for food stamps, federal deposit insurance, education, transportation, and housing.

The estimate of defense spending for 1998 is based on the Bush Administration's proposal of January 1992.

Figure 2.
Average Annual Growth Rates of Real National, Medicaid, and Medicare Expenditures for Health, Total and Per Person, 1961–1991

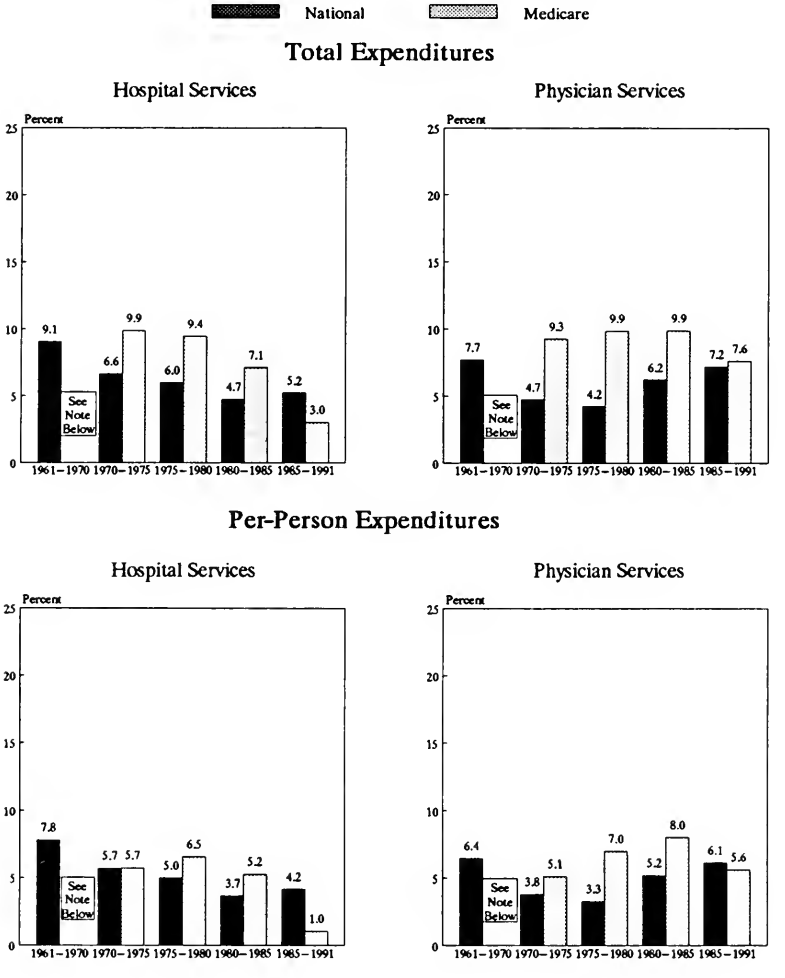


SOURCE: Congressional Budget Office calculations based on data from the Health Care Financing Administration (HFCA), Office of the Actuary, 1992. The number of Medicaid beneficiaries is based on HCFA Form–2082.

NOTES: The word "real" is used here to mean adjusted for general inflation rather than for inflation in the prices of health services, which is almost certainly different. Health expenditures are adjusted to 1991 dollars using the consumer price index for all urban consumers (CPI–U).

Growth rates are not available for total and per-enrollee Medicare expenditures during the 1961–1970 period as the Medicare program was not enacted until the mid–1960s.

Figure 3.
Average Annual Growth Rates of Real National and Medicare Expenditures for Hospital and Physician Services, Total and Per Person, 1961–1991



SOURCE: Congressional Budget Office calculations based on data from the Health Care Financing Administration, Office of the Actuary, 1992.

NOTES: The word "real" is used here to mean adjusted for general inflation rather than for inflation in the prices of health services, which is almost certainly different. Health expenditures are adjusted to 1991 dollars using the consumer price index for all urban consumers (CPI–U).

Growth rates are not available for total and per-enrollee Medicare expenditures during the 1961–1970 period as the Medicare program was not enacted until the mid–1960s.

Chairman SABO. Thank you, Dr. Reischauer.

Let me just focus on medicare and see if I understand the numbers right. The number of enrollees is projected to increase by 2 percent.

Dr. REISCHAUER. About 2 percent a year, right.

Chairman SABO. And the projections are that over the next 5 years or 4 years, the costs of the hospital program will grow at the rate of inflation plus 5 percent. Two percent of that 5 percent, can we assume, is the increased enrollees?

Dr. REISCHAUER. Various factors are at work here. One is the growth in the number of enrollees, which——

Chairman SABO. Okay, but I am just curious. Can I subtract the 2 percent from the 5 or not? You have the cost, let's assume normal inflation, and enrollees growing at 2 percent.

Dr. REISCHAUER. If we are talking about the real increase in cost, yes.

Chairman SABO. So the 5 percent is in addition to inflation and the 2 percent enrollee growth. Okay.

Hospitals are growing at 5 percent, physicians at 10 percent, outpatient at 14 percent, if I read your numbers correctly. In all the analysis I see, we get these gross numbers. I am curious. Where that additional growth, let's start with hospitals, occurs, because we do the DRG adjustment of rates, how much is that adjusted normally? Is that at the rate of inflation? If it is at the rate of inflation, we have 2——

Dr. REISCHAUER. It is an increase that is based on a medical market basket index that is calculated, I believe, by the Health Care Financing Administration every year.

Chairman SABO. So that adjustment may be higher than the normal rate of inflation for everyone else?

Dr. REISCHAUER. Or lower. It can be adjusted up or down.

Chairman SABO. Has it ever been lower?

Dr. REISCHAUER. It includes a series of inputs that hospitals buy to produce their services and looks at what has been happening to the cost of those inputs.

Chairman SABO. How accurate is that market basket?

Dr. REISCHAUER. Well, that is a little hard to tell.

Chairman SABO. Have we had any analysis of that market basket, if it varies from the normal CPI? You know, I assume their costs of energy are roughly the same as everyone else. Their personnel costs are probably relatively the same. What is unique about that market basket? Do we have any analysis of that?

Dr. REISCHAUER. The weights of the components in it, which would be labor costs, energy costs, whatever goes into the production of hospital services. It isn't the labor of the doctor.

Chairman SABO. Let's assume it is accurate. We have the DRG system in place that has in place some regulation of that adjustment. Enrollment is growing at 2 percent. Are hospital admissions growing faster than 2 percent?

Dr. REISCHAUER. The rate of hospital admissions for medicare patients actually fell during most of the 1980's. After 1984, in particular, when the new system went into effect, we had a rather sharp decline in admission rates per 100,000 enrollees. That seems to

have come to an end, and now we are seeing an upturn in admissions.

Chairman SABO. Faster than the 2 percent change in the number of enrollees?

Dr. REISCHAUER. No. I am estimating from the number of enrollees because this is admissions per 10,000 enrollees. So you have to multiply the two by each other to find out the total number of admissions.

But the increase in admissions shouldn't really be a problem because we have a hospital industry with very substantial excess capacity. The occupancy rate of hospitals is somewhere between 60 percent and 70 percent. There is no other industry that could operate year in and year out with that kind of capacity utilization without going bankrupt.

Chairman SABO. I have this problem. I still don't understand how we end up with this 5 percent growth if we are regulating the reimbursement through the DRG system and we are not having increased caseload.

Dr. REISCHAUER. You are getting more people; you are getting an increase in the price per DRG; you are getting increased——

Chairman SABO. Let me ask this question——

Dr. REISCHAUER. [continuing] complexity of diagnosis. There is some gradual creep in DRG coding.

Chairman SABO. Let me ask this question: What has been the average increase in the various DRG categories from year to year? How many are there? Are there 450, 500, something like that?

Dr. REISCHAUER. I don't have with me the exact increases.

Chairman SABO. I think it would be useful for the committee to get a sampling, just so we have for our information, what has happened to the DRG adjustments from year to year. We always have the description that they are adjusted by some X percent, and I have never seen them in numbers.

Dr. REISCHAUER. There is a procedure for determining how much they should be increased by, but the Congress or the President sometimes steps in and says——

Chairman SABO. Could we just have——

Dr. REISCHAUER. [continuing] we are not going to adjust them this year.

Chairman SABO. [continuing] what in reality they have been?

Dr. REISCHAUER. We will provide that for information the record.

Chairman SABO. When did we start, 7 or 8 years ago?

Dr. REISCHAUER. We started in 1984, and there was a period during which reimbursements were partially determined by the new system and partially determined by the old system as we phased in the new system. That lasted for a number of years.

Chairman SABO. I think it would be useful for us to know what it is about this market basket that we use for adjustments that is different than the normal CPI adjustment, and then in reality what has happened with various DRG reimbursements.

Dr. REISCHAUER. We will be glad to provide that.

[The information follows:]

Reimbursements by DRG are determined by (1) multiplying the applicable DRG weight for the discharge diagnosis and the applicable standardized amount (large urban, other urban, or rural), and (2) adding to that amount adjustments to account

for the costs of disproportionate share hospital (DSH) payments and indirect medical education (IME). These latter amounts are calculated as a percentage of the base amount determined in (1). Therefore,assuming DSH and IME law remains unchanged, increases in payments for particular DRGs are determined by the annual increases in standardized amounts from the update factor. Under current law, the update factor is based on the increase in a hospital market basket index, but the Congress has from time to time overridden the automatic update. The average increase in the update factor since 1984 has been 2.9 percent through fiscal year 1993. Over the same period, the average increase in the market basket index has been 4.6 percent, and the average increase in the CPI-U has been 3.8 percent.

However, the average payment per discharge reflects changes in average DRGs reimbursed as well as changes in the standardized amounts due to the update factor. Thus, the increase in the update factor is, by itself, not indicative of the increase in total PPS payments per discharge, which has averaged 7.0 percent per year during the same period. The growth in the average payment is high because HCFA overestimated the budget-neutral standardized amount that should have been paid in the initial year of the PPS (payments per case grew by 18.5 percent in the first year) and because use of the more complex and more costly DRGs has grown relative to use of lower priced DRGs since then.

There were 468 DRG categories in the first year of the PPS; now there are 487 valid DRG categories.

All of the above data are based on PROPAC reports.

GROWTH IN VARIOUS COST AND PAYMENT PARAMETERS RELATED TO THE PROSPECTIVE PAYMENT SYSTEM UNDER MEDICARE, 1984-1993

Fiscal Year	Growth in Market Basket (Percent)	Update Factor (Percent)	Annual Growth in Average DRG[a] (Percent)	Growth in Payments per Case (Percent)	Growth in Costs per Case (Percent)	CPI-U (Percent)	Number of DRGs[b]
1984	4.9	4.7	0[c]	18.5	6.6	4.2	470
1985	4.0	4.5	4.4	10.5	7.6	3.7	470
1986	4.3	0.5	2.9	3.1	8.5	2.5	471
1987	3.7	1.2	2.6	5.3	8.9	2.9	471
1988	4.7	2.5	3.5	5.8	9.3	4.1	475
1989	5.4	3.3	2.7	6.2	8.8	4.7	477
1990	5.5	4.7	2.2	5.0	7.9	5.0	477
1991	5.2	3.4	2.7	6.2[d]	8.6	5.1	490
1992	4.4	3.2	2.2[d]	5.2[d]	N.A.	3.0[d]	492
1993	4.3	2.7	2.0[d]	4.8[d]	N.A.	3.1[d]	492
Cumulative	57.1	33.6	28.2	96.4	N.A.	43.4	
Average Growth	4.6	2.9	2.5	7.0	N.A.	3.8	

SOURCES: Prospective Payment Assessment Commission, *Report and Recommendations to the Congress* (March 1, 1993). Figures for the CPI are from the Congressional Budget Office; figures for DRGs are from the *Federal Register*.

NOTES: CPI-U = consumer price index for all urban consumers; DRGs = diagnosis-related groups; N.A. = not available.

a. Annual growth in discharge-weighted average of DRGs paid by Medicare.

b. In 1984, two DRGs were not valid. In 1993, five DRGs were not valid.

c. First year of the prospective payment system.

d. Estimated.

Chairman SABO. Physicians are going up 10 percent, outpatient 14 percent. Again, with physicians, are the medicare recipients going to the doctor more often?

Dr. REISCHAUER. I think that is the case; the complexity of their treatment also is rising.

Chairman SABO. Let me ask the question this way: In the physician's reimbursement, that, I assume, includes both the physician's charge and charges for other costs they are incurring there, like lab tests, x-rays, whatever is done. Is that accurate?

Dr. REISCHAUER. Lab tests are done through a separate reimbursement. What you are paying for is an intermediate office visit or a long office visit for a particular diagnosis.

Chairman SABO. What I am trying to get at is: Why is it going up 10 percent? Is it because the elderly are going to doctors more frequently? Is it because the price per-visit is being raised more than inflation? What internally drives that category?

Dr. REISCHAUER. The answer is all of the above.

Mr. SMITH OF MICHIGAN. Excuse me. Could I interrupt? Could you give us a breakdown as to how much of an increase is due to those three factors?

Chairman SABO. That is what I am trying to get at. I always get these gross numbers, and I look at them, and they mean nothing to me for us to really understand what is driving the system. And the same with outpatient services. We are going to hear from GAO this afternoon, who I think have real concerns about our reimbursements there, whether they are accurate, and which is the fastest growing part of the whole system.

I think it would be useful if there is analysis which shows a breakdown of what happens with those reimbursements. I think it would be useful, again, to have a historical perspective of adjustments in reimbursements that we give to doctors in dollar terms that we can understand.

Dr. REISCHAUER. We have some information like that, though not for the medicare program, which is what you are asking for. We will do our best to get it.

Chairman SABO. Yes. I am interested——

Dr. REISCHAUER. We have it for national health expenditures as a whole, and this will give you a flavor of what CBO could do. Physician services nationally grew at 10.4 percent a year between 1990 and 1992. Our estimate is that one percentage point of this growth was due to the increase in the population per year. Two-tenths of a percentage point was because the population aged and had characteristics that required more health care, which pushed up costs. Eight-tenths of a percentage point was attributable to increased use per person. In other words, the average person went to the doctor more frequently, or something of that sort. Next, 3.3 percentage points were due to the general rate of inflation in the country. All the rest—4.8 percentage points—is the great unknown, and this was attributable to both excess inflation in the medical sector and what we call intensity of use, which is that for a particular diagnosis more procedures are being laid on. So close to half of the increase is in this other category.

Chairman SABO. Well, to the degree we could have a better subanalysis of these various cost figures, it would be helpful.

[The information follows:]

Medicare spending on physician services grows about 12.7 percent per year in the Congressional Budget Office's most recent baseline projections. The number of enrollees grows about 1.5 percent a year. The annual average growth in the consumer price index is 2.7 percent. So growth in enrollees and growth in general inflation explains only about 4.2 percent, or one-third, of the total growth. Of the remaining growth, most is attributable to more tests and procedures being done per visit and to an increase in medical charges over and above the general inflation rate.

Chairman SABO. I have used more than my time. Mr. Kasich?

Mr. KASICH. Thank you, Mr. Chairman.

Let me just pick up on one line of questioning that the chairman touched on. Doctor, wouldn't you admit that there is no market-driven way in which we set the reimbursement levels for medicare and medicaid?

I was having a conversation with Dr. Wilensky about an idea that I developed out in my district with some folks that we should bid out the procedures of medicare and medicaid. How you group them together, how precisely you do it, I am not real sure on that yet. It is going to take some analysis. But we should, in fact, bid those procedures out, and then the marketplace would set the rate.

If you had five hospitals competing to do heart surgery, for example, in Columbia, Ohio, we have 7 or 8 hospitals, and if you bid out the heart procedures and any attendant procedures you would have a different environment than what you have right now. Right now, there are some bureaucrats sitting in Washington looking at a fictitious market basket of commodities to decide what the reimbursement level ought to be?

This is not based on the marketplace setting the price. Isn't that correct?

Dr. REISCHAUER. You are correct. It is not a market in the normal sense. But I am not sure that your proposal would be as different as you might think at first glance, because you put the bid out, and the various hospitals come back with different prices. Then you have to determine that are they all providing the same quality of service. How much in the way of creature comforts are we going to allow? Because we have to remember that hospitals in America are not only medical facilities, but they are also part Ramada Inn. They provide all sorts of other services.

Mr. KASICH. But if you just assume a minimum standard of quality for all hospitals, you get into a bidding procedure. For example, we have bid out in Ohio the prison population. The hospitals in Ohio bid for the right to service the prisoners. Isn't it amazing that Ohio is saving money because one hospital decided they wanted that business so they had to sharpen their pencil? They are charging less—I mean, the State of Ohio is saving money as a result of a competitive environment.

Dr. REISCHAUER. That is the notion behind managed competition.

Mr. KASICH. That is correct.

Dr. REISCHAUER. I think managed competition moves in that direction without going all the way. What you are implying, I think, is that the low bidder gets all the business, whereas a managed competition proposal says that the low bidder's price is the maximum that will be subsidized through the tax system. And if you want to go to a hospital that costs more, you have to pay it——

Mr. KASICH. Out of your own pocket.

Dr. REISCHAUER. [continuing] out of after-tax dollars.

Mr. KASICH. Right. But that is a savings to the Government under that circumstance.

Dr. REISCHAUER. Correct.

Mr. KASICH. And, furthermore, the rates that we are setting right now for medicare and medicaid are from some bureaucrat trying to figure out the right level. It is not based on any market.

Dr. REISCHAUER. The medicaid rates are set at the State level, and the medicare rates, as you say, are set in Washington.

Mr. KASICH. Correct. So it may be——

Dr. REISCHAUER. But both medicare and medicaid, at least for hospital services, pay considerably less than the full cost of providing those services. So it is hard to argue that——

Mr. KASICH. I don't disagree with that.

Dr. REISCHAUER. [continuing] there is inefficiency there. Now, we have——

Mr. KASICH. But that begs the question of feeding the inefficiencies of the health care system. See, in other words, if all of a sudden you put hospitals, including their physicians, specialists, and administration and legal costs, into a competitive environment where they are actually bidding against each other, suddenly, instead of having 30 specialists on staff, which they don't need, they now have 15 specialists on staff, which they feel they do need. And they are able to deliver the same quality of service to the patients by becoming more efficient. Correct? And that is the idea behind managed care. It is to put the hospital universes into a competitive environment so that Hospital A competes against Hospital B, both on the basis of quality and costs.

I met with a gentlemen from the Schoteenstein Stores. They are a discount operation, and they have all their employees in a managed care system. I had the guy come to my office to talk to me about how it works, and he said, "Well, some of our employees are complaining about some of the quality?" I said, "Well, let me ask you, when you called the president of the company and told him you were thinking about getting another managed care system, what was his reaction?" He said, "He can't get to my office fast enough to figure out how to iron out the problems because they don't want to lose our business." And I said, "What has happened with your costs?" He said, "They have been restrained."

So if we were to enter into a true competitive environment, wouldn't that in and of itself bring greater efficiencies to health care and thus allow us to gain some control on this reimbursement rate for medicaid and medicare?

Dr. REISCHAUER. I doubt in the intermediate run whether medicare and medicaid reimbursement rates would go down very much. But I think overall health care spending could be significantly affected. But we are talking about some very difficult issues here.

To get those efficiencies, you would have to wring the excess capacity that now exists out of the hospital system, number one.

Mr. KASICH. Right.

Dr. REISCHAUER. You would have to shift the resources that we have more towards the allocation that exists in the rest of the world.

Mr. KASICH. Right.

Dr. REISCHAUER. Roughly 65 or 70 percent of American doctors are specialists rather than general practitioners. The reverse is true in most other countries, suggesting that we have far too many specialists, who would have to retrain and become general practitioners.

Mr. KASICH. But, you see, here is the bottom line on that. I hear all this talk about these global caps. Global caps are nothing more than price controls, wage and price controls. They were brought to us by Richard Nixon. They failed. There was a Republican that came up with a lame-brain idea, and it didn't work. Okay? To be bipartisan.

Wage and price controls don't work. But what we are talking about under this system is a competitive system that would allow us to reduce the number of specialists. But it doesn't take away from the quality of care that patients receive. Hospitals may not need 30 specialists in order to do the job. They may only need 15 specialists.

But let me just pursue a question under this area of the global budgeting, because I know there is an argument that we can't score things properly unless we somehow have a global budget. If we were to come up with a program to severely limit litigation and the defensive medicine practices—and Mr. McMillan has been a leader in this area—would we not, by restricting the amount of malpractice that a physician would have to get, in effect, be able to reduce the medicare reimbursement levels at a somewhat commensurate rate as the liability that we are reducing?

In other words, a doctor wouldn't have to buy as much malpractice, wouldn't have to have as many tests, so, therefore, we could reduce the medicare reimbursement rate commensurate with the type of action we take to eliminate defensive medicine.

Dr. REISCHAUER. Medical malpractice premiums are really a small amount. They amount to something less than 1 percent of national health expenditures.

Mr. KASICH. But if we add the defensive medicine and everything else——

Dr. REISCHAUER. Then the question is how much could you save by reducing defensive medicine. I think there is a good deal of controversy about that. There is a recent Lewin study that I believe estimates excessive tests at around $25 billion a year. Others say that would be too high. So I don't think we really know. It is not a silver bullet that is going to solve this problem entirely.

Mr. KASICH. I didn't suggest that.

Dr. REISCHAUER. Certainly it is an area in which some reform would point us in the right direction.

Mr. KASICH. But it would be possible to score savings from a litigation-relief proposal that could be generated, for example, by Republicans? We could say that we are going to do X, Y, and Z to affect the practice of defensive medicine, and, therefore, we think we can realize this amount of savings. That would be proper, wouldn't it, and scorable?

Dr. REISCHAUER. If there were a clear mechanism that we saw resulting in lower medicare or medicaid reimbursement rates. But,

as I said before, medicare and medicaid are reimbursing below costs now——

Mr. KASICH. No, we don't know that they are reimbursing—I mean, in the environment in which we presently live, they may be.

Dr. REISCHAUER. At the hospital level they are. There is a question of how you measure this with respect to physician services, which is where this would be most important.

Let me say one thing. If you say there will be expenditure caps, CBO does not naively go out and assume they are going to be effective and score savings associated with that. We require that the legislation include various aspects to enforce those caps—to bring those caps down to the hospital level or to the doctor's office level—to get any scoring for them.

On the other hand, with respect to managed competition proposals, it is not true that we don't suggest that savings, sometimes substantial savings, could be generated by those types of reform.

Mr. KASICH. I don't want to belabor this. There are many members with other questions. But if we were to have super managed care systems, as the gentleman from Tennessee has suggested—and I applaud him for his efforts—and combine that with managed care of medicare and medicaid, would that not create a more highly competitive system that would work to cut the number of specialists, the over-supply of equipment? Wouldn't that force these hospital universes to become a lot more concerned about their costs? Wouldn't that put them in a position of where they would, being more competitive against one another, figure out a way to do business more efficiently while still keeping in mind quality?

Dr. REISCHAUER. Managed competition?

Mr. KASICH. Yes.

Dr. REISCHAUER. You said managed care twice.

Mr. KASICH. Managed competition.

Dr. REISCHAUER. Managed competition with some clear incentives to the buyer of the insurance through a change in the way we allow pre-tax income to be diverted to health care needs would have a substantial impact, yes. I agree with you.

Mr. KASICH. Thank you, Mr. Chairman.

Chairman SABO. Mr. Kildee.

Mr. KILDEE. Thank you, Mr. Chairman.

Doctor, medicare reimburses at less than cost. That gap, then, must be made up elsewhere by private insurance companies and industries like the auto industry that provide health care for its workers and its retirees. Now, we know that the price of a car is greater by $600 to $800 because of the health care costs.

What percentage of cost does medicaid reimburse a hospital, and what percentage of cost would, say, the auto industry reimburse a hospital?

Dr. REISCHAUER. I don't know the figures for the auto industry. The estimates for medicaid nationwide are that it reimburses at about 80 percent of hospitals' costs; private insurers, on average, reimburse at about 128 percent. So they are paying 28 percent more than full costs. Medicaid is paying 20 percent less. Some of that is made up through other kinds of payments from State and local governments to hospitals. Not all of it is picked up by——

Mr. KILDEE. Let's take kind of a closed situation in Genesee County, Michigan, where General Motors was established, where David Buick and Louis Chevrolet lived. We have medicaid patients at three, four hospitals there. One hospital takes more of the medicaid patients than others.

Now, if medicaid is reimbursing the hospital at 80 percent, then they do have to get the money elsewhere. Probably the greatest other provider in Genesee County is really the auto industry. So the auto industry then must be paying maybe 120 percent of costs, then, right, to take care of the deficiency in the medicaid payment?

Dr. REISCHAUER. Possibly. That would be a perfectly plausible set of numbers.

Let me go back to something you said before because I think there is a widespread misunderstanding in America about how health care costs feed into final prices of products. Most economists would argue that employer-provided health care benefits, in fact, are not provided by the benevolent employer, but are provided out of the worker's hide in the form of lower cash wages. The employer decides how many people to hire based on total compensation costs: wages and salaries, the unemployment insurance tax, the FICA tax, the vacation benefits, the health care benefits, and other benefits that he has to provide.

The actual distribution of total compensation between wages and salaries on the one hand and benefits on the other is not of particular concern to the employer. All he cares about is that bottom line.

He is really shifting the cost of health insurance onto the employee over the long run. So the cost of the car doesn't go up because of health care insurance. The cash wages received by the auto workers go down. And what we have seen over the last decade or so is that roughly half of the increase in total compensation has gone into these benefit costs.

So we ask ourselves, why are cash incomes going up so slowly in America, particularly for factory workers? The answer in large measure is that much of the compensation that they should or could have received in cash form has been transformed into added benefits.

Mr. KILDEE. I think where you may be wrong, Doctor, is that the costs of other areas are more controllable. The cost of what the worker has to pay for groceries and housing is more controllable. The really uncontrollable area right now is health care.

Now, you talk to the Big Three, and they are deeply concerned about health care costs.

Dr. REISCHAUER. They have a particular problem, which has to do with retiree benefits.

Mr. KILDEE. Exactly.

Dr. REISCHAUER. And that really does come out of their hide. They have no way of shifting that onto current workers because current workers, obviously, would leave and work for a company that had fewer retirees.

Mr. KILDEE. You know, the transplants, the Japanese transplants, for example, they have generally a younger, healthier work force with no retirees yet.

Dr. REISCHAUER. Any new firm, whether it is a foreign transplant or a domestic enterprise, starts off with no retiree benefits

and, therefore, is at a competitive advantage in the short run. And the short run might last 20 or 30 years, so for all practical purposes it is a lifetime.

Mr. KILDEE. I think there is no question. I talk to my hospitals there in Flint, and they know that they have to stick it to the auto industry because they don't get reimbursed enough through medicaid and they have to transfer it over to the auto industry, which does, no question, add to the cost of the car. You know, my Dad joined the UAW back in 1935, and I know that when they negotiate, there is so much money on the table, except the other areas they get reimbursed for are much more controllable than the health care area. And I think that is where you should look into that part.

Dr. REISCHAUER. But if you are a benefit manager——

Chairman SABO. Why don't we hold that? We have lots of folks. Mr. McMillan?

Mr. MCMILLAN. Since we don't seem to be getting very far with statistics, I would like to read from First Corinthians.

[Laughter.]

Mr. MCMILLAN. "For we know in part, and we prophesy in part. But when perfection comes, the imperfect disappears. When I was a child, I talked like a child, I thought like a child, I reasoned like a child. When I became a man, I put away childish things. Now we see but a poor reflection, as in a mirror. Then we shall see face to face. Now I know in part. Then I shall know fully, even as I am known."

We are not looking at the facts. Part of our problem in dealing with the future is the fact that we can't analyze the past. You have a difficult time—and it is not your fault; it is in the nature of things—explaining why medicare and medicaid are increasing at the rate that they are. I know there are a lot of reasons, and they include all of the above.

But this Congress has written legislation or not written legislation that has created an open-ended health care system out there in which there are no controls. We sit up here, and we criticize Reagan and Bush for not having solved the budget deficit problem. The fact of the matter is that the budget deficit for the past decade has been driven by the entitlement programs that are not defined specifically enough to get them under control. Neither of those Presidents had veto power over the—in fact, they are not included in the budget year in and year out and, therefore, are not really a part of the current discussion. Yet, that is what is driving the budget deficit.

You know, we could do away with the defense program, we could do away alternatively with domestic and discretionary spending and still wouldn't balance the budget. The problem is in these programs. The fact that we are having such a difficult time describing what has happened is the reason why we are inadequate at this point to deal with the future.

I think a lot of it has to do with the changing nature of medical care, some of which has been stimulated by medicare and medicaid. The doctors raise Cain, or the hospitals, if medicare doesn't cover their costs, or medicaid. The fact is there are a lot of people in the hospitals today getting treatment that weren't getting it 20 years

ago. Maybe the reimbursement rate is not 100 percent, but the payments, the cash flow is enormous. It has fueled or spawned a development of a health care delivery system that we are not paying for and someone else is not picking up the difference. I think that is what we have got to honestly address.

My mother is 89 years old. I had to put her in the hospital last week. In the space of 9 days, she got two CAT scans and one MRI. I am not going to quibble about that, but they wouldn't have been there 10 years ago.

Medicare reimbursed them. Did Congress pass a law saying we are going to reimburse for CAT scans and MRI's and under what conditions are we going to reimburse for CAT scans and MRI's?

We don't consider standards of practice when we set up reimbursement rates. We reimburse on a per-item deal. Therefore, the system out there can just pile on stuff into medicare and medicaid. Maybe it doesn't reimburse 100 percent, but the volume grows.

You mentioned that 4 percent of physician fees increases out of 10 percent were attributable generally to additional specialties being applied. That probably is true. That may be even an understatement. Then if you add to that the cost of those specialties, what those doctors are ordering, then it expands geometrically. That I think is part of what we are into.

We really need some help, I think, in developing a way to deal with this. The global budgeting approach would micromanage, it seems to me, the whole system. We have been trying to micromanage the system, it seems, through medicare and medicaid—unsuccessfully.

We need to decide what percentage of payments we are going to make. It is my understanding that medicare, when it began, was only designed to reimburse 50 percent of the costs. Is that correct?

Dr. REISCHAUER. No, I don't think so. You might be referring to the Supplementary Medical Insurance program. The premiums that individuals paid when medicare was established were set to equal 50 percent of that component's costs. So the beneficiaries in a sense made insurance premium payments equal to 50 percent of the total costs of supplementary medical insurance.

Mr. MCMILLAN. Was it ever written into law what percentage of the expected cost Government was undertaking to pay?

Dr. REISCHAUER. No, it wasn't. But a trust fund was established for the hospital insurance program, and the theory——

Mr. MCMILLAN. But the trust fund is based upon some assumptions about the cost of care, or should be. I think that is part of our problem. We have not really been willing to face up to what assumptions we are operating under.

Dr. REISCHAUER. Well, no one foresaw the tremendous revolution that was going to occur in medical care and the costs thereof. And these programs say basically that we will provide, for certain of the poor and the aged, medical services as defined by the medical community and others that improve medical outcomes.

Mr. MCMILLAN. Well, I would say——

Dr. REISCHAUER. So you are dead right. There is no limit placed on these.

Mr. MCMILLAN. Let me just close with this: I think there is a potential solution to defining what the Federal role is and also facili-

tating a competitive system out there that may not bid out business on a one-shot basis but constantly rebids. That is the use of a politically incorrect approach which is called vouchers or certificates that basically can be 100 percent of the expected cost of care, or purchasing total insurance, scaled down by income to zero. That cuts across the board, and that then becomes the currency with which the system out there can get a competitive response. That is certainly something that I want to explore as an alternative.

Thank you very much for your testimony.

Chairman SABO. Mr. Coyne?

Mr. COYNE. Thank you, Mr. Chairman.

Dr. Reischauer, in recent days we have heard about a possible $35 billion cut in the medicare program over 5 years. Do you have any sense of who that ultimately is going to affect—the enrollees, or is more going to be on the provider side?

Dr. REISCHAUER. I know no more about this than you do from reading the newspaper, and what I have seen is speculation that the medicare reimbursement rates, both for the DRGs and for the relative value scale, would be frozen. That would reduce the amount that providers, primarily hospitals and physicians, received.

The way to affect beneficiaries directly, of course, is to raise the monthly premium in the SMI portion of medicare. That was done in the 1990 budget agreement, and maybe it will be done again. But I haven't seen any——

Mr. COYNE. I am just wondering if the providers cuts, as you just outlined, would ultimately work their way down to the recipients.

Dr. REISCHAUER. The way such cuts work their way down to the recipients is usually through access, that fewer doctors are willing to be participating physicians in the medicare program. Something like half of the doctors in America are participating physicians, so there might be some reduction in access.

But we have to remember that medicare is a very large, important program that controls a significant fraction of total hospital and physician reimbursements in this country. So it is not too easy for a physician to say, "I am not going to participate in this program," or, "I am not going to serve these patients."

Mr. COYNE. On another subject, the——

Dr. REISCHAUER. There is another problem, of course. All of the evidence suggests that when you hold down or cut reimbursement rates for physicians, they have the ability to increase the volume of services—to have you come back twice for what they might have done in a single visit before—and thus maintain their incomes, or at least partially offset the loss of income that would have been associated with the reduction in fee schedules.

Mr. COYNE. Recently, the inspector general at Health and Human Services has indicated that one way to curb the costs of the medicare program is to raise the age at which you can receive benefits to 67. Is it likely that if we were to adopt that, that would create another pool of uninsured in the country?

Dr. REISCHAUER. I think it would because people primarily receive health care through employers or public programs. And it might increase the age of retirement. But, of course, many Americans retire before the age of 65 as it is. Those who retire early tend

to be those who can get health care benefits through their former employer as a retiree. So what you might be doing is shifting a larger cost onto American industry, and, as I said before, this cost doesn't come out of the current work force. It is hard for employers to shift it onto the current work force, so the problems that companies like General Motors face in a competitive environment, which Mr. Kildee pointed out, would be exacerbated and spread throughout the Nation if we did that.

Mr. COYNE. Thank you.

Chairman SABO. Mr. Kolbe?

Mr. KOLBE. Thank you, Mr. Chairman.

Dr. Reischauer, thank you for coming and sharing some of your thoughts on this almost impossibly difficult topic.

In your statement, you made some comment about the fact that the prospective payment has helped to give incentives to hospitals to operate more efficiently. What evidence do we really have for that? Have we been able to measure the efficiencies as opposed to the cost shifting that is going on?

Dr. REISCHAUER. Well, we went from a system that basically reimbursed hospitals for whatever they did——

Mr. KOLBE. I understand.

Dr. REISCHAUER. [continuing] where we said do something and send us the bill, to a system in which we said if this person has an appendectomy of modest proportions, you get X dollars whether the person stays in the hospital 1 day or 11 days. After this system went into effect, we saw that lengths of stay in the hospital went down rather substantially for medicare patients. We also saw hospital margins rise very rapidly because, by not using resources that maybe weren't absolutely needed, they could, in a sense, make a profit. The margin is the difference between the payments going in and the cost of the resources for the treatment, and these shot up quite significantly in the mid-1980's after this system went into effect. So it is obvious that hospitals cut back on their costs.

Mr. KOLBE. Trying it from a different angle there, do we really have any real evidence, though, that we are seeing competition—the suggestion of efficiencies all suggest there is competition going on on the basis of price. There is a lot of competition going——

Dr. REISCHAUER. No, no. This wasn't created that way. It was really an incentive that said if you use resources efficiently, you can keep whatever you save because we are paying you a flat fee for this diagnosis and treatment.

Mr. KOLBE. All right.

Dr. REISCHAUER. That is very different from competition between different providers.

Mr. KOLBE. Okay. Let me try it this way, and then I want to come back to the price issue. What evidence do we have that this system has resulted in cost shifting to the private pay?

Dr. REISCHAUER. Well, we have the number that I just provided you, which was that the average private insurer pays 128 percent of costs.

Mr. KOLBE. Okay. So it has been——

Dr. REISCHAUER. I doubt if that would occur——

Mr. KOLBE. If you didn't have——

Dr. REISCHAUER. [continuing] if the hospitals didn't have to shift costs somewhere.

Mr. KOLBE. The suggestion that we don't know precisely what it would be, but that we might cut—that President Clinton has suggested that we might cut—medicare costs by as much as $35 billion primarily by further reduction of payments to hospitals and doctors, can you project what kind of additional cost shifting we will have as a result of that? Will it be 100 percent?

Dr. REISCHAUER. We haven't made an estimate like that, but I would assume that part of it obviously will come out of the quality, the level of services that hospitals are providing, and part of it will come out of——

Mr. KOLBE. More cost shifting.

Dr. REISCHAUER. More cost shifting.

Mr. KOLBE. Would you agree that there is not a lot of evidence that we see competition among hospitals based on cost, that we see a lot of competition on quality? You see that all the time in advertising; you know, have your spouse come on in and have dinner with wine in the hospital with you in the room, all kinds of amazing things, and some very good things. But you receive very, very little competition on the basis of cost, if any. Is that not true?

Dr. REISCHAUER. I think it was true, but it is becoming less true because large purchasers of medical care, be they Calpers, a public employee purchaser in California, or large corporations or large insurers are negotiating with hospitals and getting special rates, discount rates, in effect. So it is becoming more common that under a managed care environment your insurer might say, if you go to Hospital A, B, or C, we will pay the full cost of it; if you choose another hospital, you are going to have to pay 20 percent coinsurance. That kind of thing. This is based on the fact that your insurer or your company has negotiated with the hospitals to get a special rate.

Mr. KOLBE. Well, okay. I will leave that because my time is limited, otherwise I would like to follow up on some other issues, maybe, and come back to that. But let me just ask you at least one other question.

Dr. REISCHAUER. I am saying there is more of this than there used to be. I am not saying that we have no competition here at all. Don't get me wrong.

Mr. KOLBE. Yes, because I just wonder whether we are not just engaging in some other kinds of cost shifting there.

Dr. REISCHAUER. I think that is true, too.

Mr. KOLBE. On medicaid, do you think that allowing the States—medicaid is a curious system because, of course, as we know, it is a mix, State and Federal. There is some flexibility to the States to design their own programs. They have certain requirements and minimums. Do you think that if we gave more flexibility to the States, as we have talked about the laboratories of democracy to reform the medicaid system, that we might find more effective ways to utilize this program? If so, do you have any suggestions about incentives we might give to States that could discover ways to deliver that health care to the medicaid population in a more cost-effective way?

Dr. REISCHAUER. Remember that States right now pay 43 cents of every medicaid dollar, and while that is not paying the full dollar, it should provide them with some pretty strong incentives. This is also one of the largest and fastest growing elements in their budget.

Mr. KOLBE. Excuse me for interrupting, but we have significantly limited what they can or can't do in terms of what kind of services they provide that population, though, right?

Dr. REISCHAUER. Well, virtually all of the States provide more services than the basic required level. Most States provide a rather full range of additional services. I think their perspective is that they are going to have to pick up the medical costs for these low-income people one way or another, so they might as well do it through the medicaid system and get Federal reimbursement for part of it. So what you have seen is States expanding into areas of providing services and care for developmentally retarded children and mentally impaired people, because these, which used to be fully State-funded programs, can now be partially paid through the medicaid system.

Mr. KOLBE. Well, my final comment—okay. Thank you, Mr. Chairman.

Chairman SABO. Congresswoman Mink?

Mrs. MINK. Thank you very much.

Welcome again, Dr. Reischauer. I am very concerned and interested about the medicaid program because I think that this program bears some degree of scrutiny. I had always understood that the medicaid program had income eligibility criteria for participation. Is that not a true fact, that the States are required to provide programs based upon certain income criteria?

Dr. REISCHAUER. There is a group of people who are categorically eligible. These are the individuals who are receiving AFDC or SSI benefits, and, of course, AFDC——

Mrs. MINK. Everyone in that program is covered.

Dr. REISCHAUER. Yes. AFDC benefits vary State by State. So the limit, obviously, is different from State to State.

The Congress has also adopted a series of mandates that require States to provide care for pregnant women and children below a certain level of poverty, 133 percent of the poverty line. So States cover that on a uniform basis.

Then there is a component of the medicaid program that says if you have unusually high medical expenditures, such that when you subtract these medical expenditures from your total income you get down to an income level that would qualify you for low-income status or AFDC status, you are eligible for medicaid, too. So it is a mish-mash, but they are not——

Mrs. MINK. So how do you explain the statement in the material that has been provided which states, "Despite the increasing number of people eligible for the medicaid program, only about half of the population with income at or below the poverty level was covered by medicaid in 1991?" How do you explain that half of the people that are below the poverty line are not even being counted, and yet we see this rising cost item in our budget?

Dr. REISCHAUER. Many of those people are single individuals, who would not fall into any category that I just described. Some of

them are childless couples. They are young or late middle age or older, and they would not be covered.

As I said, we have this procedure now in which we are covering children in low-income families, but we are phasing them in. Everybody under 19 will be covered by the year 2002, I believe, but I think we are only at the 9-year-olds this year. So you could be a low-income family, either a single-parent or two-parent family, with teenage kids and none of you would be eligible under these circumstances. So those are the people who make up this half of the poverty population that is not covered.

Mrs. MINK. So if the Federal Government made a decision in looking at this overall health reform requirement and decrying the fact that 35 million people are not covered, and in looking at that picture made a decision to cover every individual that fell below the poverty level, taking into account the other definition of a medically needy person, what would be the additional sums of money that would be required to fund such a program?

Dr. REISCHAUER. I was afraid you were going to ask that.

Mrs. MINK. Sorry.

[Laughter.]

Dr. REISCHAUER. I don't have a number. We can make an estimate for you.

[The information follows:]

If Medicaid benefits were extended to everyone in families with income below the federal poverty line, we estimate that federal spending would increase by $14.3 billion. Because the costs of the Medicaid program are shared by the federal and state governments, state spending would increase by about $10.8 billion. Some 10.7 million individuals who are currently uninsured would become eligible for the new Medicaid benefits, reducing the number of people without health insurance by almost one-third.

Mrs. MINK. It seems to me that that is just one very easy way to meet this whole issue of providing care to a group that is already identified by other Federal standards.

Dr. REISCHAUER. I think there are 50 Governors who might not agree with that statement because they would be picking up 43 percent of every dollar spent on this. It would be a huge additional burden on State governments, which already view themselves as overburdened.

Mrs. MINK. I am talking in the overall review of our health coverage programs. That is certainly one way that we could tackle that problem.

Dr. REISCHAUER. Many of the proposals that are before the Congress would do this in a different way. The managed competition bill of Mr. Cooper would provide for a full Federal subsidy for all individuals with incomes below poverty and a partial subsidy for those with incomes between 100 percent and 200 percent of poverty. So there are other ways of doing it besides expanding medicaid.

Mrs. MINK. Now, the States have had enormous difficulty in funding this program, and you hear the anguished cries from all of the State capitals. In much of what they say, they attribute the increased costs and their problems to the fact that Federal laws changed which mandated these additional costs, additional coverage, or the Federal regulations increased the cost.

Could you elaborate on that, exactly what the impacts have been over the last, say, 2 or 3 years of new Federal laws and regulations and what this cost factor is with respect to the 43 percent share of the State?

Dr. REISCHAUER. That is an issue that is subject to considerable debate right now. We have a basic medicaid program that would be expanding quite rapidly anyway, even if none of the Federal mandates had been adopted, because the economy is weak and so a lot of people are being thrown into jobless status, and also because there have been some court decisions, which would have occurred anyway, that are forcing States to pay higher reimbursement levels to providers. So it is almost impossible to separate those increases from the various expansions that have taken place during the 1980's—the major one, of course, being the mandate that low-income pregnant women and children under certain ages be covered.

Chairman SABO. Why don't you provide that information in writing?

Dr. REISCHAUER. Okay.

Chairman SABO. Also, under medicaid there are a variety of State options of expanded benefits. If you have any record of what States have exercised those options and which have not, we would appreciate that information so we know what potential obligations are out there that we have not dealt with.

Dr. REISCHAUER. Okay.

Chairman SABO. It would be very helpful.

[The information follows:]

Several factors have contributed to rapidly rising Medicaid expenditures in recent years, including enrollment expansions, service enhancements, and reimbursement changes, some of which were mandated by the federal government. Many states, however, have voluntarily expanded eligibility and enriched their Medicaid benefits beyond the mandated requirements. It is not possible to separate the effects of mandatory eligibility expansions and program enhancements from the effects of voluntary ones.

Given the limitations of Medicaid data, it is difficult to measure the relative contributions of different factors to Medicaid expenditure growth. A study conducted by Dr. Steven Long at the RAND Corporation, however, throws some light on this issue. In 1991, Medicaid expenditures rose by $19 billion. Dr. Long concluded that almost 40 percent of that increase reflected historical trends and 60 percent represented increases in expenditures above the historical trend projection. Most of that "excess" growth was accounted for by increases in the number of beneficiaries above the 1980–1988 trend, and the remainder represented increases in spending per beneficiary in excess of medical inflation.

Nominally, the federal government pays an average of about 57 percent of Medicaid costs, with state and local governments paying the remainder. (The federal financial participation rate varies by state according to per capita income. Currently, the federal share ranges from 50 percent to 79 percent.) In the last two years, however, states have raised the effective federal matching rate above its nominal level through the use of provider taxes and donations. Those financing devices have enabled states to generate additional federal matching dollars without corresponding expenditures of state funds.

Most states provide many services for Medicaid patients in addition to those that are required by the federal government. Furthermore, in July 1992, the following 30 states (and the District of Columbia) had income eligibility ceilings for pregnant women and infants above the federally mandated level of 133.3 percent of poverty: Arizona, California, Connecticut, Delaware, Florida, Hawaii, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Oklahoma, Rhode Island, South Carolina, Tennessee, Texas, Vermont, Washington, West Virginia, and Wisconsin.

Mrs. MINK. Thank you very much, Mr. Chairman.

Chairman SABO. Mr. Miller.

Mr. MILLER. Thank you, Mr. Chairman.

Let me ask a couple questions about the cost factor that you brought up. One was the question of excess capacity. You say there is a 60, 70 percent utilization in hospitals. What is the solution to that? A lot of bankruptcies?

Dr. REISCHAUER. The solution is to close hospitals at a faster rate. That is a very difficult thing because you are trading off access. In some cases, what you are talking about is closing a rural facility, which would make people go longer distances, but there is also underutilization of capacity within metropolitan areas where transportation and access shouldn't be a particular problem.

But we also clearly have excess capacity of high-technology machines, and the discussion of the two CAT scans and the MRI is a classic example of that. We could use our expensive machinery much more efficiently and limit the use to which it is put.

Mr. MILLER. Is the Federal Government doing anything to help reduce this excess capacity, or is it just the market kind of working its way right now?

Dr. REISCHAUER. The Federal Government really isn't doing anything. It is terribly difficult to do. You know, what we have sometimes is a community that has a Catholic hospital and a Protestant hospital, and both are operating at 60 percent of capacity. So there is a different factor that is brought into the decision on closing one of them.

Mr. MILLER. But a significant part of our cost problem is the over-capacity, excess capacity; is that right?

Dr. REISCHAUER. I think so, yes.

Mr. MILLER. Related to that, and we haven't discussed this, is the veterans health care system. I saw in the paper recently where the Secretary was saying, well, one way to get more money into the health care system for the veteran program is to bill more medicare and medicaid. Well, you know, if we look at the total dollars, it just seems like it is not the great logic to be using right there when we have to look at the total dollars of health care. Are you aware, or what is your familiarity with this subject that the Secretary——

Dr. REISCHAUER. We haven't looked at that, but obviously if you shifted services to the veterans health care system, you would be drawing them away from other facilities, and the excess capacity in the other facilities would rise.

Mr. MILLER. Did you see the quote from the Secretary?

Dr. REISCHAUER. I heard him on the radio, yes.

Mr. MILLER. Okay. So it is a concern of yours. It seems like the right hand and left hand have to get together on this.

One other question about the cost factor. Health care is a very labor-intensive business, and what is your view as far as making it more labor efficient? Are there a lot of efficiencies to be achieved? If you look at studies of kids coming out of college and what jobs to go into, health care is always one that is picked on with a great future, which portends more costs of a labor-intensive business. Is there much that can be done on the labor intensity side of the equation?

Dr. REISCHAUER. I think health care has actually become much more capital-intensive over the years as we have substituted machinery for people. If you think about what has happened now in the nursing world, there is a patient, and they plug the patient into all sorts of electronic monitoring devices. One nurse at a centralized station monitors 15 or 20 patients rather than having somebody go and open the doors every half-hour or so to see how the patients are doing. There are a lot of areas like that where capital has been substituted for labor, and the labor that we are putting into this industry, of course, has become more human-capital-intensive. You have to train longer. You have to have more expertise.

Where the greatest growth is occurring is in areas like nursing home care, which is partially medical and partially basic living help.

Mr. MILLER. One last question. One way of reducing costs is reducing usage, of course, and DRGs, which came in 1984, have been successful. Correct me if I am wrong, they have been successful and they have not affected quality of care. But that is what is causing a lot of the rise in nursing homes and home health agencies.

Dr. REISCHAUER. And outpatient treatment.

Mr. MILLER. Right.

Dr. REISCHAUER. We shifted things from the hospital to outpatient venues.

Mr. MILLER. Are DRGs recognized by both the medical profession and the industry as being successful?

Dr. REISCHAUER. Well, I speak for neither the medical profession nor the industry, but if by successful we mean reducing the amount of unneeded hospitalization and not having an adverse effect on outcomes, they would be regarded as successful.

Mr. MILLER. DRGs are basically managed care in just one component. The hospital is managing the care within that one component rather than the fee-for-service medicine.

Dr. REISCHAUER. Yes. The hospital is given a lump sum payment to treat an individual, so in a sense this is a capitation system by diagnosis.

Mr. MILLER. So it is considered a success from an economic point of view.

Dr. REISCHAUER. From the analytical viewpoint, which is what I speak from, the answer is yes.

Mr. MILLER. How about from the quality standpoint, are you aware?

Dr. REISCHAUER. There have been studies of that, and generally the feeling is that it has not adversely affected quality.

Chairman SABO. Mr. Miller, your time has expired.

Mr. Orton?

Mr. ORTON. Thank you, Mr. Chairman.

Dr. Reischauer, welcome, and thank you for your testimony. I am curious to what extent CBO, or to your knowledge GAO, may be examining and analyzing the various programs. We have 50 different States out there which are laboratories.

For instance, following up Mr. Kasich's point on changing the tort liability laws, my State of Utah and neighboring Colorado and others in the country have established very stringent restrictions

on tort liability, in fact far more stringent than the AMA even recommends. I am wondering if there have been any studies about the incidence of what is called defensive medicine in those States, and if there have, if it shows a decline in defensive medicine practices with a restrictive tort liability law in place.

And rather than going into details——

Dr. REISCHAUER. I am not aware of any studies of that, and probably it is too early to tell. I believe these changes were made in the last couple of years.

Mr. ORTON. Utah has had it in place 5 years; I believe Colorado has as well. There should be some empirical data that we could start looking at, and that's something I would suggest that we start doing.

Dr. REISCHAUER. Right.

Mr. ORTON. Also, in my State of Utah and other States, the States have enrolled a large percentage of the population eligible for medicaid into managed care. This should be distinguished from managed competition. As you know, it is not the same thing. But I am wondering if the enrollment of medicaid patients in managed care programs has shown any effect in reducing the growth of costs in these States, and a followup, given that 70 percent of medicaid costs go to long-term care, do you believe that managed competition would hold any hope for keeping down medicaid costs without some complete systemic reform of the medicaid program.

Dr. REISCHAUER. A lot of questions there. The movement of medicaid recipients into managed care is a relatively new phenomenon. People are looking at it and examining the impact. Most of the people who have been affected by this are women and children rather than the elderly and disabled, and they have been moved into some of the looser forms of managed care, rather than being enrolled in group or staff model HMOs, which are the form of managed care that we know can significantly reduce total costs. They have been enrolled in programs that provide them with a gatekeeper, in effect, and some of the emphasis has actually been on making sure these individuals get the appropriate care that they need, which could boost expenditures rather than hold them down. So most analysts are not expecting big savings from that form of managed care as applied to the medicaid population.

You are right with respect to the limited ability of managed competition to deal with the nursing home and severely disabled population. That's a very difficult issue, and it is not one that is laid out in great detail in most of the managed competition proposals.

Mr. ORTON. Given that medicaid already has in place three fairly major cost control components which you have already talked about in your testimony—namely, narrowly defining the range of services that is eligible; a State cost-sharing mechanism, and a requirement for paydown by the individual before they are eligible—what do you believe would be the most important changes that we could make to the medicaid program to contain costs in medicaid? Is there anything we can do to contain medicaid costs? We already have these three fairly major cost containment provisions in there.

Dr. REISCHAUER. I would disagree with you on the first of those three. The basic benefit package that is required by the Federal Government may not be extremely broad, but the average benefit

package that is provided by the average State, in fact, has broader coverage than any insurance policy I have ever had in my life.

Mr. ORTON. So we could narrow the definition of what is eligible for treatment.

Dr. REISCHAUER. We could narrow the definition and limit the States' ability to provide a lot of ancillary services, and at the same time——

Mr. ORTON. Some people call that rationing health care.

Dr. REISCHAUER. It would be rationing health care; it would be denying eyeglasses or dental care or whatever to the low-income population, and that is——

Mr. ORTON. Okay, but that being one, are there other major reforms which you could recommend that would have an impact on lowering costs of medicaid? I am realistically looking—the President has suggested we can cut $35 billion out of medicaid—we are looking at this, and we are told by you that——

Dr. REISCHAUER. That's medicare he is talking about. Medicaid is a pretty bare-bones program right now. It is reimbursing doctors and hospitals at very low rates relative to what they get from other providers on a per-person basis. If you look at the amount that is paid for women and children, who would be more like the regular working population, this is a program that spends a lot less than the average middle-class or working-class family spends on health care.

Mr. ORTON. I guess that's my point.

Dr. REISCHAUER. So there is not a lot of fat.

Chairman SABO. The gentleman's time has expired.

Mr. ORTON. Thank you. I have a number of other questions. I would like to ask permission to submit them in writing for response?

Chairman SABO. No objection; so ordered. They will be in the record.

[The questions of Hon. Bill Orton and responses to same follow:]

Question: Would extending the Medicare Fee Schedule to everyone help to hold down health care costs?

Response: If the Medicare Fee Schedule (MFS) were applied to all non-Medicare services as well, spending on physicians' services would fall by perhaps 5 percent overall. This drop in spending would occur because rates paid by private insurers are higher than Medicare's rates, on average, although rates paid by Medicaid are lower. In addition to this one-time drop in spending, growth in spending thereafter might also be lower, for two reasons. First, rates paid by private insurers have tended to increase more rapidly than Medicare's rates in the past. Second, the relative value scale that underlies the MFS incorporates a relative reduction in payment rates for the procedural services that are typically provided by specialists. In the long run, this realignment of payment rates might induce more medical students to train for general practice and fewer to enter specialty training. In this case, not only would fewer expensive procedural services be provided, but also the ancillary services that are recommended by specialists more than general practitioners might be cut back.

Question: Given that far fewer Medicare recipients are enrolled in managed care programs, does the extensive use of managed care or managed competition hold any hope of restraining the growth of costs?

Response: Managed care encompasses a broad range of approaches for avoiding unnecessary use of health care resources. These approaches, however, are not all equally effective in containing costs. Staff model and group model health maintenance organizations (HMOs) are the forms of managed care for which the largest savings have been demonstrated.

All care funded through the Medicare program and almost all care funded through private health insurance is now subject to one managed care approach or another. Only 4 percent of Medicare enrollees belonged to staff and group model HMOs in 1990, however. In contrast, about 8.6 percent of people who were insured either privately or through public programs other than Medicare and Medicaid belonged to staff and group model HMOs in 1990.

In principle, therefore, expanded use of staff and group model HMOs within the Medicare program should have the potential to reduce total Medicare spending from the levels it would otherwise reach—possibly by 10 percent to 15 percent if everyone in the Medicare program were to join such an HMO.

If Medicare's HMO program were to expand in a more limited way, however, the implications for Medicare's spending could be different. This is because evaluations indicate that the Medicare enrollees who have chosen—voluntarily—to join HMOs are healthier on average than those who have not. One study found, for example, that Medicare expenditures on behalf of HMO enrollees in the two years preceding their HMO enrollment were only 79 percent, on average, of expenditures for Medicare beneficiaries who did not join, after accounting for age, sex, and other factors considered in the methodology used to determine Medicare's capitation payments to HMOs. Because Medicare HMOs appear to be experiencing "favorable selection" in this way, Medicare is probably paying more now for the care of HMO enrollees than it would if they received their care under fee-for-service arrangements. Consequently, further voluntary expansion of HMO enrollment within Medicare would not result in savings unless Medicare's method for setting its reimbursement of HMOs could be adjusted to reflect more accurately the average costs of caring for those Medicare enrollees who joined HMOs.

Whether managed competition could achieve savings for Medicare would depend on several factors. The most basic is whether any system of managed competition that was established would incorporate the current Medicare program. Most proposals have assumed that Medicare would be excluded, at least initially. Another factor is whether, under a system of managed competition, Medicare would be paying providers a higher percentage of their actual costs than it does now. For example, the Prospective Payment Commission has estimated that, in 1990, Medicare's reimbursement to hospitals covered about 90 percent of the costs that the hospitals incurred when caring for Medicare enrollees. A third factor is the extent to which the introduction of managed competition would lower the average cost of providing health care or the rate of growth in this average cost.

Question: Apparently there have been recent changes in the way CBO scores the savings from any health care reform plan. Could you briefly explain those changes?

Response: We have altered our estimating techniques for proposals that involve global expenditure limits. Since last summer, we have consulted a number of experts and have read a number of published studies on the effectiveness of various control mechanisms in the health area. We have examined both the limited experience with global budgeting within certain geographic areas of the United States and have looked at the experience of other industrialized countries.

CBO will examine the expenditure limits contained in a proposal with respect to both the stringency of the limits and the specified enforcement mechanisms. Based on our review, we will then rate the effectiveness of each expenditure limit. A fully effective limit would receive a 100 percent effectiveness rating; a completely ineffective limit would be rated at zero. The estimated savings for the expenditure limit would equal the difference between the cost of the bill without the limit and the limit times the effectiveness rating.

We are hopeful that this estimating approach will allow us to provide realistic estimates of proposals containing expenditure limits.

Question: How much revenue could be collected for the federal government if the ceiling on the wage base for Medicare taxation is eliminated and the federal subsidy for Part B is reduced to 65 percent?

Response: Current law exempts wages above the maximum taxable earnings level ($135,000 in 1993) from the Medicare Hospital Insurance tax. Repealing the maximum earnings level for Medicare, beginning January 1, 1994, would increase revenues by $2.9 billion in 1994 and by $29.2 billion from 1994 through 1998. If the premium in the Part B program were raised to 35 percent of program costs, leaving a federal subsidy of 65 percent, federal spending would be reduced by an estimated $3.5 billion in 1994 and by $46.0 billion from 1994 through 1998.

Question: According to recent data released for Medicare, Part B outlays dropped significantly for the first time in several years while the growth in Part A outlays remained strong. Do you think the decrease in growth for Part B is directly attributable to the implementation of the Resource-Based Relative Value Scale (RBRVS)?

Is there any evidence of a lag in collections of Part B claims? Do you think more cost shifting is simply occurring?

Response: Medicare Part B benefit payments have grown an average of 13.0 percent per year from 1985 through 1991. Data from 1992 are not yet complete, but early examination suggests lower rates of growth in 1992. The implementation of the Medicare Fee Schedule could have contributed to this lower rate of growth; however, we are still analyzing the data. In addition, the processing time by the carriers seems to have increased.

We are currently awaiting final data on 1992 to determine how much of the decline in growth is due to a real decline in payments and how much of it reflects a slow down in the payment process.

We do not have data for other payers and are therefore unable to address the question of cost shifting at this time.

Chairman SABO. Mr. Price?

Mr. PRICE. Thank you, Mr. Chairman.

Dr. Reischauer, I appreciate your testimony today. It helps us prepare for what are going to be some very important decisions this year that I hope and expect we will be taking.

Let me go to the matter of how we pay for medicare, where the funding for that program comes from. You indicate that payroll taxes, that is, moneys collected from the active work force, account for 54 percent of medicare funding; general revenues, 37 percent, and then premiums paid by the beneficiaries themselves, only 9 percent.

Then in your testimony, you have some additional figures as to how hefty that subsidy really is for the beneficiaries, suggesting an annual subsidy of something like $2,000; is that right?

Dr. REISCHAUER. That's for the hospital insurance program alone.

Mr. PRICE. That's for Part A alone?

Dr. REISCHAUER. Yes, and then there would be Part B, and the subsidy would be three-quarters of the total Part B cost per enrollee.

Mr. PRICE. Historically, is that 9 percent figure a historic low? What has been the trend there, and how does that compare to what was originally anticipated when this financing structure was established?

Dr. REISCHAUER. None of the framers had the wildest idea where this program was going, so any reference back to 1964–1965 would be like looking through the looking glass, in a way.

As I said at the beginning of my testimony, the SMI premiums originally were set to equal 50 percent of the total cost of the SMI program. I believe the SMI program has grown faster than the HI program over the years, and I would expect that the current 9 percent might not be a historic low, because we raised premiums 3 years ago, but we are bouncing close to the bottom in terms of the contribution of current beneficiaries to the overall cost of the program.

Mr. PRICE. Now, of course, these beneficiaries have paid a medicare tax through a portion of their working years.

Dr. REISCHAUER. That's where we got the $2,000. What we did was look at the amount of tax that had been paid on their behalf by them and their employers plus the interest that might have been earned by that sum until the point they retired; then we looked at the average amount of hospital services they were going to receive over the rest of their life and discounted that; and we

arrived at about a $2,000 difference between the two. So that figure takes into account their contribution.

Mr. PRICE. And I was going to ask you to slice that statistic another way and to estimate how quickly the average retiree plays out the insurance benefit of what he has paid in medicare taxes. How soon does the subsidy kick in after retirement?

Dr. REISCHAUER. I don't have the exact number for you, but it would be just a couple of years, I would think.

Mr. PRICE. Lower than the 5 to 6 years that we are now hearing is the figure for social security; considerably lower than that.

Dr. REISCHAUER. The HI contribution rates were very low for a long period of time, and hospital expenditures, of course, have been rising at an extremely rapid rate. For the average male worker—one who had worked all his life at sort of an average wage—the SMI and HI benefits together would come to about $3,800 a year for a beneficiary who turned 65 January 1st of 1992. This is a substantial amount of money.

Mr. PRICE. Now, assuming that some kind of premium adjustment was an equitable way to reduce the amount of that subsidy, is there some feasible way, do you believe, to means test the premium one pays?

Dr. REISCHAUER. If you just raise the premium, of course, those elderly people with very low income would be affected as well as the retirees in Palm Beach. As I said before, the medicaid program is now required to pay the premium for individuals with incomes below 110 percent of the poverty line, so people who are very poor would be protected.

But another way of doing this, and one that is detailed in our deficit reduction book, would be to take the average subsidy amount and treat it as taxable income. So you would send people the equivalent, I guess, of a 1099 form, and they would add this to their income. The vast majority of the elderly would still be below the tax threshold so they would be unaffected by it, but those at the very top would pay the equivalent of 31 percent of this subsidy value.

Mr. PRICE. Since my time is about to expire, let me move very quickly to a related line of questioning having to do with the RVS system. That system, as you point out, was not designed mainly as a cost saving measure in the first place. It was designed more to equalize the payments to various specialties.

You suggest here, though, that there has been a 1-year savings since that was instituted——

Dr. REISCHAUER. No.

Mr. PRICE. [continuing] or, that's the way I read it—but that overall, those costs were still going up, that it really was not having any kind of cost saving result. It, of course, wasn't mainly designed for that, but I would still like to know your analysis of that and also what are the kinds of mechanisms that might be utilized to get some savings in Part B?

Dr. REISCHAUER. The law——

Chairman SABO. Would you be good enough to ask him to put it in the record?

Mr. PRICE. Fine. If you will put that in the record, that is an important question, I think.

Chairman SABO. And not only put it in the record, but send it to Mr. Price.

Dr. REISCHAUER. Yes, we can do that.

Mr. PRICE. Thank you, Mr. Chairman.

[The information follows:]

By law, full implementation of the Medicare Fee Schedule (MFS) was supposed to be budget neutral. Because the Health Care Financing Administration (HCFA) assumed that introducing the MFS would generate an increase in the volume of services billed to Medicare, it reduced the level of the blended rates paid in 1992 by 3 percent, and it reduced the level of the fully implemented rates by 6.5 percent, to compensate for the expected volume increases.

There has not yet been enough experience with the MFS to determine its effects on Medicare spending with any certainty. Outlays for 1992 and early 1993 have been below expectations, but the reasons are unclear. One reason may be that the overall increase in volume predicted by HCFA in response to the MFS was too large. Another reason may be that payment of claims was slowed because of the coding changes that were implemented along with the MFS. In the latter case, the slowdown in spending will be quickly reversed.

In principle, spending could be controlled either by reducing the rates paid per service, or by introducing limits on the number of services provided. For 1994, according to CBO's projections, substantial savings could be had by forgoing the volume-based adjustment to the payment rate update, and setting the update equal to the unadjusted increase in the Medicare Economic Index. Unlike all other years in the projection period, the volume-based adjustment for 1994 would *increase* the update because actual spending growth in 1992 was below the target rate of growth set by law. However, both CBO and HCFA estimate that half of the savings one might expect from such a payment rate change would be offset by increases in volume.

Savings could also result from better utilization review activities. HCFA eliminated its preadmission certification requirements for certain hospital stays in 1991, although there is evidence from other insurers that such requirements are cost-effective. Instead of case-by-case oversight, HCFA intends to introduce retrospective review of physicians' practice patterns during 1993, in an effort to change the behavior of those with aberrant and costly patterns. HCFA argues that this type of utilization review is both more cost effective and less intrusive than case-by-case oversight. Many believe that HCFA's activities in this area have been hampered, however, by inadequate funding for these administrative functions.

Chairman SABO. Mr. Allard?

Mr. ALLARD. Thank you, Mr. Chairman. I have several questions, and we'll try and get through those if we can.

In your testimony about spending for medicare, you mentioned that hospital spending is estimated to increase about 8 percent between fiscal year 1992 and 1993 compared with 38 percent for home health care and 22 percent for hospice care and 28 percent for skilled nursing facility care.

It's my understanding that you are looking at total dollar expenditures in those areas. However, I didn't see anything that reflected the rate of change of utilization. In other words, I see a lot of growth going on in home health care because the States are pushing people into a home health care situation.

Do you have any figures that could assist us in making some sort of an estimation in the growth of home health care. With the current 8 percent growth in hospital costs, it may reflect that hospital costs aren't growing as quickly as those other areas, but in reality it may be because there is less utilization. I just wondered if you could respond.

Dr. REISCHAUER. I think that's a very good point. In some cases, the alternative to home health care might have been a longer stay in the hospital, which would have pushed up the hospital compo-

nent more. All of these components are in a sense intertwined, and holding one down doesn't necessarily mean you aren't going to affect the others.

Mr. ALLARD. Okay. So are you going to be trying to gather some information on the number of people using home health care services and the number of people in hospitals, so those numbers will mean more to us? The way they are right now, I don't think they mean a heck of a lot to this committee, frankly.

Dr. REISCHAUER. I think you are right that there is certainly an increase in numbers of people using home health care and an increase in the per-person use of health care. We can provide to you and for the record whatever data exists——

Mr. ALLARD. If you could do that.

Dr. REISCHAUER. [continuing] on the expected growth in the numbers.

Mr. ALLARD. It would be helpful if you could do that.

[The information follows:]

Within the Medicare program, the average number of home health visits per enrollee per year has grown fairly steadily, with one period of interruption. This average number grew from 0.43 in 1975 to 1.36 in 1984, declined to 1.14 in 1987, and subsequently rose to 2.05 per enrollee in 1990. The Health Care Financing Administration has projected continuing increases until 1997 in the average number of home health visits per Medicare enrollee, the average reimbursement per visit, and total Medicare spending on home health visits. [See House Committee on Ways and Means, *1993 Green Book* (May 1993), Table 37, pp. 212-213.]

In contrast, the average number of discharges from short-stay hospitals per aged Medicare enrollee rose from 0.324 in 1975 to 0.381 in 1983, then declined to 0.302 in 1989. Average lengths of stay also showed a downward trend over this period.

There is no firm evidence that home health services have been substituted for hospital services since Medicare adopted the prospective payment system (PPS) of hospital reimbursement. Those who hypothesize that substitution has occurred might point to three arguments. The PPS created incentives for hospitals to discharge patients earlier than before and to substitute care from skilled nursing facilities or home health agencies; home health agencies have developed a growing capacity to provide sophisticated, technologically intensive care; and more hospitals are reportedly providing home health care services, which are reimbursed separately from inpatient care.

Nevertheless, a systematic analysis of variations among states in hospital and home health use under Medicare and of changes over time in this use rejected the substitution hypothesis. Using a variety of measures, it found no evidence that shorter hospital stays had resulted in more extensive use of home health services. [See C.R. Neu and Scott C. Harrison, *Posthospital Care Before and After the Medicare Prospective Payment System* (Santa Monica, CA: The RAND Corporation, 1988).]

Mr. ALLARD. The other question I had is that you talked about the SMI program, and in 1993, you said $46 billion in general revenues will be necessary by 1998. Is that general revenues from payroll taxes, or where is that general revenue—just out of the general fund?

Dr. REISCHAUER. It's out of the general fund. "General revenues" is actually a misnomer, because when you are running a $300 billion deficit, of course, some of those revenues come from borrowing from Wall Street, from the issuance of Treasury notes and bonds.

Mr. ALLARD. So the people in the SMI program are paying the $36.60 per month——

Dr. REISCHAUER. Right.

Mr. ALLARD. [continuing] and then we have money not coming out of the Medicare Trust Fund, but it is coming out of the general fund; is that correct?

Dr. REISCHAUER. Yes, general funds or general revenues are transferred into the SMI trust fund, I believe.

Mr. ALLARD. So they are transferred——

Dr. REISCHAUER. From the Treasury.

Mr. ALLARD. [continuing] from the Treasury into the SMI Trust Fund.

Dr. REISCHAUER. Right.

Mr. ALLARD. Okay. Also, you had stated that the medicare hospital insurance will pay 60 percent more in benefits per enrollee over their lifetime than the value of their contributions than those made by their employers. How did you arrive at this percentage? How did you calculate that 70 percent?

Dr. REISCHAUER. As I told Mr. Price, basically what we did is take the average person retiring in January 1992 and say, let's give him average wages back to the beginning of the medicare program, which was 1965, and we'll tax those at the rates that existed, put in a special place his contributions, his employer's contributions, and the interest associated with——

Mr. ALLARD. So I guess what I am driving at is did they have time value of money? You did have interest on that figured in? That's what I was wondering.

Dr. REISCHAUER. Yes.

Mr. ALLARD. Okay. Very good. There are a number of States that have applied for waivers in the medicaid program—Colorado for one; I think Oregon has another, and I think Arizona has a waiver. Do you believe that allowing those States waivers in the medicaid program would save dollars at the Federal level?

Dr. REISCHAUER. Most of the waivers that I am familiar with have been an attempt by the States to rationalize their provision of services to low-income individuals. They asked, "Why are we concentrating all of our resources on only half of the low-income individuals? There might be a better way to do this and spread it out more evenly." The waivers that have been granted by and large have been ones in which the Federal Government says it doesen't want to be liable for any more than it would have had to pay under the old system, but States can go up to that.

So I think it is more rationalization than cost saving that is involved. But I'm not familiar with all these programs, so it is conceivable that there are cost savings involved in some of them.

Mr. ALLARD. Yes. I think the States are making those decisions, and it seems to me that we ought to give them the flexibility to go ahead and use those waivers, and those programs that are working the best, the other States would gravitate to those. And since it is a match with the Federal Government, it seems to me that it would just automatically reflect in some sort of a decrease in expenditures at the Federal level.

Now, it also was pointed out earlier in the testimony that the medicaid insurance, for example, is a much broader policy than the average person owns out there and what usually goes into private insurance, and I think that those States would look at that and ask what do we want to provide in the way of good, basic medical care.

Dr. REISCHAUER. Yes, broader because States have decided to provide additional services, not necessarily because the basic benefit package is broader. The required benefit package——

Mr. ALLARD. So you are saying the States voluntarily had those expanded——

Dr. REISCHAUER. States have voluntarily expanded the package a great deal——

Mr. ALLARD. What drove the States to do that?

Chairman SABO. The gentleman's time is up.

Mr. ALLARD. Well, I would appreciate a response to the question on what drove the States to do that.

Chairman SABO. Why don't you submit that for the record so he can respond?

Mr. ALLARD. All right. Thank you.

[The information follows:]

States have expanded their benefit packages beyond the basic requirements because they want to provide important services to their Medicaid populations, many of whom—such as the elderly, the disabled, and pregnant women—have special healthcare needs that they probably could not pay for themselves.

Furthermore, even in the wealthiest states, half of the costs of providing additional services are picked up by the federal government, and in the nine states with the lowest per capita incomes, the federal government pays at least 70 percent of the costs.

In some cases, the Medicaid program enables states to obtain federal matching dollars for services that they might have provided anyway, such as institutional care for mentally retarded people, which is an optional Medicaid service. In addition, state and local governments can reduce their subsidies that pay for uncompensated care in hospitals if more low-income people are covered by Medicaid.

Chairman SABO. Mr. Costello?

Mr. COSTELLO. Dr. Reischauer, I'd like to ask a question about the issue of fraud in the health care field in general medicare and medicaid. I wonder if you have any numbers as to an estimate as to the percentage of money that the Federal Government pays out for medicare and medicaid that is processed and paid out as a result of fraudulent claims on the part of doctors and health care providers?

Dr. REISCHAUER. I don't have any numbers of that sort. I think the General Accounting Office is the best source for that kind of information.

Mr. COSTELLO. You have no idea—you have not looked at that issue?

Dr. REISCHAUER. No, we have not looked at that issue.

Mr. COSTELLO. Do you have any idea what the Federal Government is doing about the issue of fraud?

Dr. REISCHAUER. No, I don't.

Mr. COSTELLO. You indicated in your testimony, both here and in your written testimony, that you are estimating a decline in medicaid spending from the peak levels of 1991 and 1992. Can you explain why?

Dr. REISCHAUER. Well, medicaid spending was driven up very rapidly in part because of the recession, and the recession is over; the economy should be recovering. As it recovers, people will get jobs, and some people who are on medicaid should leave the rolls. That is reason number one.

Reason number two is that there has been a surge in coverage of certain disabled individuals that was associated with some court decisions, and once the backlog of cases like this is over, the growth rate should slow down.

And third, we are going through a period in which States are responding to the Supreme Court decision in the Virginia case that upheld a certain interpretation of the Boren amendment—which requires States to pay reasonable and adequate amounts to providers through the medicaid system—so we are getting a ratcheting up of medicaid reimbursement rates. The level of medical spending is still going to be very high; it's just that the rate of growth won't be as astronomical as it has been over the last few years. Also, we are phasing in these new populations that are required under the mandates, and that will be over within a few years.

Mr. COSTELLO. But regardless of what happens to the economy if we are out of the recession or not, there is a large percentage of the people who are receiving medicaid benefits today who are elderly—the bulk of the people are elderly and disabled as opposed to those who are just out of work or——

Dr. REISCHAUER. The bulk of the dollars are spent on only 30 percent of the beneficiaries, and those individuals and the spending on them are clearly not sensitive to changes in the economy.

Mr. COSTELLO. Very good.

Thank you, Mr. Chairman.

Chairman SABO. Thank you.

Mr. Hoke?

Mr. HOKE. Thank you, Mr. Chairman.

I wanted to go back to some of the issues that Mr. Orton began to explore, and make a couple of observations and find out what your reaction is.

It seems to me that we are pretty much neophytes in the business of government-provided health care in this country compared to other countries, particularly in Western Europe, and that we do very much have a rationing problem because we don't have a two- or three- or multi-tiered system; we really only have one level of health care in this country, and that is probably the world's highest level of health care that is available.

And yet in other countries that do provide government paid-for health services, there are very much delineated tiers of service that are available, and what somebody gets who is on the government program is very different from what an individual who is not receives.

It seems to me that this is probably one of the reasons why we have runaway health care costs in the United States, because we don't distinguish or differentiate the level of care that is going to be available as between people who are being paid for as what is called an entitlement and they perceive it to be an entitlement, and yet in fact it is very much a subsidized entitlement, subsidized by the rest of the taxpayers, as distinguished and contrasted to those individuals who are paying themselves personally or through a privately paid insurance program.

It seems to me that in order to actually reduce costs, either we have to give people a financial incentive to be well, a financial incentive not to see a doctor or use a health care facility, or we actually have to provide as government a lesser standard of care, a bare-bones standard of care, something that does not give the same two MRIs and/or two CAT-scans and an MRI, that Mr. McMillan's mother received.

And I know—and you backed off of it immediately, because obviously, this is almost a third rail—because we come out of a very different tradition. We come out of an egalitarian tradition, we come out of a democratic tradition where everybody gets the same. Everybody deserves the same and ought to be treated the same. So to suggest that those people whose health care is being provided for by the government deserve less than those who are paying for it themselves is something that you just should not even broach.

Well, I am broaching it, and I wonder what CBO's response is to that way of recognizing that one of the reasons that costs have escalated out of sight.

Dr. REISCHAUER. Well, our government programs are the medicare and medicaid programs, and I would characterize neither of them as being gold-plated in terms of level of coverage.

Mr. HOKE. Excuse me. I think you said just moments ago that the coverage of medicaid exceeds any insurance policy that you personally have had in your own life.

Dr. REISCHAUER. The coverage meaning the type of benefit that is covered in the average state. That is very different from looking at the reimbursement rate and trying to go to a doctor with that reimbursement rate as full payment. Probably no doctor that I have ever been to probably would accept that as full payment. So we have a very complex issue here. On the one hand, medicaid covers a great deal in some States—eyeglasses, dental work, various rehabilitation services that might not be covered under my Blue Cross/Blue Shield plan. But on the other hand, it pays very minimal amounts, so these people go to what many people would regard as second-rate providers.

Medicare, in contrast, is a fairly narrowly——

Mr. HOKE. Let's explore that for 1 second, because I think that you may be mistaken there. I mean, when you talk about Blue Cross/Blue Shield, if your physician is participating in a UCR program, the amount that he is actually reimbursed——

Dr. REISCHAUER. Is considerably less.

Mr. HOKE. [continuing] is considerably less. At it may be, as Mr. Kasich was suggesting earlier, that if we put some of these things out for bid, you'll find that there are plenty of health care providers who are more than willing to provide those services at the levels that are being paid for right now by medicaid.

And there is a way to determine quality with respect to that by doing outcome studies, and all of that information is available. And it could be mandated that if you are going to participate, you've also got to provide the outcomes information.

Chairman SABO. A quick response, and then we'll have to move on.

Dr. REISCHAUER. My judgment is that very few of the doctors that any of us in this room go to would sign up to participate in medicaid under the current reimbursement limits and with the additional requirement that they provide data on the outcomes of their treatments.

Mr. HOKE. Thank you.

Chairman SABO. Mr. Mollohan?

Mr. MOLLOHAN. Dr. Reischauer, as I understand—and I'd like to know if you agree—there is a reimbursement formula, and as I un-

derstand, the formula is based purely on geography—the urban physicians are paid more than those practicing in rural areas——

Dr. REISCHAUER. That is true to the extent that the value scale includes practice costs in it, and its assessment of practice costs in rural areas—rent, utilities, overhead, whatever—is less than in urban areas. But in theory this reflects the costs of running an office, not the reimbursement for the human capital that the doctor has.

Mr. MOLLOHAN. Overhead costs. So to the extent that's correct——

Dr. REISCHAUER. It shouldn't be viewed as a discriminatory factor.

Mr. MOLLOHAN. The problem exists as I understand it that in rural areas, doctors are still performing services at less than cost. And first of all—and Congressman Kildee reminded us that there is a lot of cost-shifting—it is, at least in my experience as I talk with doctors, frequently the case that a very high percentage of these rural doctors' practice is a medicare practice. Consequently, they don't have as great a patient population to shift costs to, which results in the anomaly that while you are reimbursing them less for overhead purposes, there is less of an opportunity for them to cost shift if you follow that line of reasoning.

Do you agree with that line of reasoning?

Dr. REISCHAUER. To the extent that any provider has a high proportion of medicaid and medicare patients, his or her ability to shift is clearly reduced. But on the other hand, remember that we went from a system that involved the usual, customary, reasonable charges to one that is much more uniform across areas, and that should have in a sense——

Mr. MOLLOHAN. I am not addressing where we came from; I am addressing where we are.

Dr. REISCHAUER. Well, with respect to cost-shifting, I think you are right.

Mr. MOLLOHAN. Okay. So the problem is that that provides a disincentive for doctors to practice in rural areas because of the access problem that I referred to in my previous question.

I guess my question to you is do you have any idea of what savings to the government is associated with that differential, and what costs would be involved in addressing the problem?

Dr. REISCHAUER. "Differential" meaning the practice cost differences across the——

Mr. MOLLOHAN. No. I am talking about the differential of how much it saves if you agree that there is a problem in providing a disincentive for doctors to practice in rural areas, therefore creating a real access problem, some way you must get at that. So there is, yes, a cost of living or an overhead cost factor here—it costs less to practice in rural areas—and that's a benefit to the rural doctor. But there is also this problem of not being able to shift the cost, so that's a minus. While you have a plus up here, you have a minus down here. And that provides disincentive as far as practice in rural areas, and that's a real problem to get doctors to practice there if they aren't going to make money, or make as much money. So what is the——

Dr. REISCHAUER. I don't know the answer to that, but I think there are a lot of other factors that discourage doctors from practicing in rural areas that are probably much more important.

Mr. MOLLOHAN. Arguably there are, and that's something I would like to explore. I can tell you it is a great concern to rural doctors and it affects the practice, because so much of their practice is in the medicare area, so that they do not have opportunities to shift costs.

I'd like for you to explore that more for the record, if you would.

Dr. REISCHAUER. Fine.

[The information follows:]

Although almost all physicians treat at least one Medicare patient during the year, the limited information that is available suggests that Medicare payments are concentrated on a minority of physicians whose revenues come mostly from Medicare patients, both in urban and rural areas. If this conclusion is correct, neither urban nor rural physicians have much capacity to "shift costs"—that is, to raise fees charged to non-Medicare patients.

There is no evidence, however, to indicate that rural or urban physicians found Medicare's rates too low to cover costs in 1990. A 1990 survey by the American Medical Association found that 94 percent of physicians had some Medicare patients, 96 percent accepted some new Medicare patients, and 80 percent accepted all new Medicare patients. These results did not differ appreciably between urban and rural physicians. Because the Medicare Fee Schedule (MFS), implemented in 1992, increased payment rates for rural physicians significantly relative to urban physicians (by about 40 percent, comparing the most rural locations with the most urban ones), rural physicians are less likely now to find Medicare's payment rates to be too low to cover their costs than they were in 1990.

The comparative improvement in rural payment rates under the MPS should help to induce more newly trained physicians to practice in rural areas, as does the 10 percent bonus that Medicare pays to physicians in Health Professional Shortage Areas. Many analysts believe, however, that higher payment rates are only a partial solution and that other measures will be necessary to compensate for the disadvantages of rural practice. These disadvantages include long distances to hospital facilities, poor access to continuing medical education programs, and too few other physicians with whom to interact and form group practice arrangements to reduce each physician's on-call time. Some policy options that would increase the health care resources available to physicians and patients in rural areas include, for example, mobile medical facilities, medical transport services, and telecommunication systems to facilitate physicians' consultations and continuing medical education. In addition, medical schools might be encouraged to recruit students from rural areas and to provide residency training positions in rural areas.

Mr. MOLLOHAN. Thank you.

Chairman SABO. The gentleman's time has expired.

Mr. Pomeroy?

Mr. POMEROY. Dr. Reischauer, I was very interested to note in the material before us that over the next 5 years, medicare's share of the Federal budget is expected to go from 9.2 percent to 12 percent, moving to 13 percent in 1997, and that this is driven by (1) an increase in persons eligible which accounts for 10 percent of that increase, (2) rising reimbursement rates which accounts for 26 percent of that increase, but (3) increases in the utilization and intensity of services provided accounts for 63 percent over this period of time.

This statistic, coupled with the information that the individuals employed in health care services has risen 43 percent in 4 years, leads me to the question: Do you see the explosion of medical services as a snowballing phenomenon, where in increasingly short periods of time, we are providing more and more elaborate and comprehensive services?

Dr. REISCHAUER. That certainly has been the story of the last decade or so. I think the country has finally received a wakeup call on this, and a lot of attention is being paid at the national and State and industry levels to doing something about it. So I would expect that the pace of this explosion will subside, although it will still far exceed the growth in the economy.

Mr. POMEROY. Will it subside without meaningful health care reform passed by this or a future session of Congress?

Dr. REISCHAUER. I believe it will subside somewhat, but not sufficiently to satisfy the American people, without some attempt to address this at a national level. It's an impossible thing to do, as I suggested in my statement, either to grab one part of this beast to control it or to do it piecemeal in the various States.

Mr. POMEROY. Many of my colleagues this morning have mentioned medical malpractice as a contributor to defensive medicine driving the number of procedures provided. It has been my experience as a State insurance commissioner that physician self-referral or some type of production-based reimbursement for physician-controlled clinics has been also a significant driver of medical costs.

Do you have an evaluation of that?

Dr. REISCHAUER. No, we haven't done anything on that.

Mr. POMEROY. I don't have any more questions.

Chairman SABO. Ms. Snowe?

Ms. SNOWE. Thank you, Mr. Chairman.

I'd like to welcome you as well, Dr. Reischauer. I know the hour is getting late, and I have just a few questions in two different areas.

One is the possibility of the Clinton Administration imposing price controls on health care and establishing a global health budget. How effective do you think that would be in controlling health care expenditures, and would that not lead to providers increasing the volume of services—or, would you have to limit both in order to make it effective?

Dr. REISCHAUER. Yes, you would. I certainly don't know what the Clinton Administration is thinking of doing. If caps or expenditure limits were placed at the national level with no translation of them down to the provider, either at the State level or even below the State level, they would be largely ineffective.

The response of providers during the Nixon-era price controls was to offset their reduction in fees with increases in volume. That's easy for some specialties and some types of doctors to do; it is harder for others. For instance, if you are an anesthesiologist, it is hard to run the same patient through anesthesia several times; that is determined by the number of surgical procedures. But there will be some offset of that sort unless there are also volume controls.

Ms. SNOWE. As you know, at least according to what we have heard, President Clinton will be proposing a $35 billion cut in medicare. We have heard a lot about cost-shifting in order to accommodate the reduced payments to hospitals and doctors. Do you think that cost-shifting could occur in this instance by reducing those payments to doctors and hospitals with the $35 billion cap?

Dr. REISCHAUER. I think the $35 billion figure is actually the total savings over a number of years, maybe 4 years.

Ms. SNOWE. That's right.

Dr. REISCHAUER. And to the extent that this represented a permanent shift downward as opposed to just a temporary step that was taken before full-fledged health care reform went into effect, I think the effects would differ. But if we kept this in place for a long time, I think the response you suggested would be there.

Ms. SNOWE. On medicaid again—and I know that this issue has been fully discussed here this morning—but it is a major problem given the skyrocketing increases that you mention in your testimony and certainly indications for the State.

You don't have a dollar value in terms of what the Federal mandates represent vis-a-vis private health insurance coverage?

Dr. REISCHAUER. No, we don't.

Ms. SNOWE. You don't. Could you provide that to the committee, because I think that would be important. You talked about State options, and it's true that they can provide additional services, optional services, because they can get additional funding from the Federal Government, also the reverse is true—they cannot reduce any of the mandates that the Federal Government imposes on the State, so they lack the flexibility and the latitude to address some of these funding issues.

Now, what would you think about a block grant in medicaid?

Dr. REISCHAUER. It would be terribly hard to know how to distribute the block grant. Medicaid spending per State varies tremendously, and it is not necessarily associated with the number of low-income individuals in the State. Spending is determined in a sense by State preferences, so it would be nonsensical, I think, to hand out a block grant equal to the current distribution among States.

If you switched to a more reasonable or logical type of formula, which might consider cost differences among States and numbers of low-income people whom the Federal Government was concerned about, and you didn't want to spend any more money than we are spending now, a situation would arise in which immense amounts of resources would be taken away from some States and other States would receive windfalls. So it is a very difficult process to get from here to there, I think.

Ms. SNOWE. Yes, there are tremendous variations from State to State in terms of the optional services that they provide.

Dr. REISCHAUER. That's right, and in terms of the reimbursement levels to providers.

Ms. SNOWE. I just think it would be interesting to evaluate the Federal mandates in terms of what that represents in health insurance coverage compared to private health insurance and whether or not that would be sufficient in terms of the Federal Government's responsibility and the role that it plays in the medicaid program.

You made some reference to the fact about recent expansion of benefits under medicaid for children under the age of 19 and families with income below the poverty level. What did that represent in terms of cost to the Federal Government and to the States? Was that the most recent mandate from Congress?

Dr. REISCHAUER. This was first mandated in 1984 as an optional service, and then in the mid-1980's it was required; then, in 1990, the income level was raised along with the number of years that a

child could be eligible. So it has been, in a sense, a creeping mandate. It didn't all come into effect at one time or get passed at one time. We've expanded it throughout the 1980's and 1990.

Ms. SNOWE. So we don't have the value of the cost of that mandate, which would be the most recent one.

Dr. REISCHAUER. No.

Ms. SNOWE. Could you provide that for the committee as well?

Dr. REISCHAUER. I am not sure methodologically that we can, but I'll provide whatever we can to you and to the committee.

Ms. SNOWE. Okay, thank you.

Chairman SABO. In addition to that question, would you also provide to us a description of what the options are? My understanding is that States have the option to go up the income scale——

Dr. REISCHAUER. Right, to 185 percent of poverty for children below a certain age.

Chairman SABO. Yes. And then there is another cutoff for older children.

Dr. REISCHAUER. That's right.

Chairman SABO. And if we could have a description of what those various options are that are available to the States, with some number attached to what we mean by "x" percent of the poverty level. I have difficulty at times relating that to what actual dollars are.

Dr. REISCHAUER. Family incomes; right. Okay.

[The information follows:]

All states must provide the following benefits to their categorically needy Medicaid beneficiaries: hospital services; physician services; laboratory and X-ray services; family planning services; nursing facility services for persons over age 21; home health care for persons entitled to nursing facility services; Early and Periodic Screening, Diagnosis, and Treatment program services for people under 21 years old; services provided by rural health clinics and federally qualified health centers; and the services of nurse midwives, certified pediatric nurse practitioners, and certified family nurse practitioners (in states where those providers are authorized to practice).

The mandated Medicaid benefit package differs from a standard health insurance plan in several important ways. From a cost perspective, however, the two major distinctions are Medicaid's coverage of long-term care and prohibition on most forms of cost sharing. If a policy with both those features could be purchased in the private sector, it would be extremely costly. Because of low reimbursement rates, however, state Medicaid programs probably do not pay as much for the mandated benefits as would a private insurer.

The states report that they will spend an average of about $2,300 per Medicaid beneficiary for mandated services in 1993. (That may be a slightly high estimate because it includes all dental services, most of which are optional.) By contrast, current projections indicate that an average employment-based policy will cost about $1,700 for individual coverage and about $4,500 for family coverage in 1993.

Every year between 1984 and 1990, the Congress passed legislation giving states options or mandates to expand Medicaid eligibility. The most recent mandate, which was included in the Omnibus Budget Reconciliation Act of 1990 (OBRA-90), requires the states to cover all children under age 19 born after September 30, 1983, in families with income below the poverty level ($11,890 for a family of three in 1993). Thus, all poor children under age 19 will have Medicaid coverage by the year 2002.

Unfortunately, the available data do not allow us to track the actual costs of this mandate. At the time that the legislation was passed, however, CBO projected that it would cost the federal government about $560 million over the 1991 to 1995 period, with over 40 percent of the costs occurring in 1995. (Since a new cohort of children is added each year, annual costs will continue to rise every year until 2002.) Assuming that the federal share of Medicaid expenditures remains at about 57 percent, that estimate translates into a total increase in Medicaid expenditures of almost $1 billion for the five-year period.

As a result of previous legislation, states must also provide coverage to all pregnant women and children under the age of 6 in families with income below 133.3 percent of poverty. In addition, they have the option to provide coverage to infants under 1 year old and pregnant women in families with income below 185 percent of poverty.

Beginning in 1993, OBRA-90 also requires states to pay Medicare Supplementary Medical Insurance premiums for Medicare beneficiaries who meet the required asset tests and have income below 110 percent of poverty. That income eligibility criterion will rise to 120 percent of poverty in 1995.

Chairman SABO. Okay. Thank you very much. We appreciate you being here today and answering all the questions of our members. Thank you very much, Dr. Reischauer.

Dr. REISCHAUER. Thank you.

Chairman SABO. The committee is adjourned.

[Whereupon, at 12:15 p.m., the committee was adjourned.]

[Additional material submitted for the record follows.]

PREPARED STATEMENT OF HON. LUCIEN E. BLACKWELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

Mr. Chairman, I want to first commend you for calling this hearing on Federal health care problems. Holding this hearing on the eve of President Clinton's announcement of his proposed economic stimulus and deficit reduction package, demonstrates your understanding that we really can't discuss deficit reduction without discussing the spiraling costs of health care.

The American health care system is in deep trouble. Health care spending is out of control. As a result, millions of Americans with health care coverage are unable to afford any care beyond the bare essentials. Millions more go without coverage altogether. The cost of providing health care to America is expected to rise from $838 billion in 1992 to an estimated $939 billion in 1993, and to more than $1.7 trillion by the year 2000.

In my State, there are fathers with jobs, standing in the soup lines, bent and broken because needed medical care cost $50, and they only had $5. There are families forced to make choices between long-term care and college tuition. There are mothers, with children, unable to ease their pain and suffering because the cost of prescription drugs has gone beyond their means to pay. This is a crisis we can no longer ignore.

Driven by seemingly uncontrollable medicaid and medicare costs, Federal spending for health care is one of the leading causes of the Federal budget deficit. According to the Congressional Budget Office, medicaid costs will increase from $68 billion in 1992 to $146 billion by 1998, and will comprise about 9 percent of all Federal spending in 1996, compared with 3 percent in 1990. Medicare costs will increase by an average of 12 percent between 1994 and 1998. Those increases are on top of the projected spending of $134.1 billion in 1993 for medicare, an amount that represents 9.2 percent of total Federal spending. Fraud, abuse and poor management exacerbate the problem.

The high cost is putting health care beyond the reach of more and more Americans. Over the past 3 years, some 13 percent of employers with 50 or fewer employees have eliminated health care coverage as a benefit of employment. Currently, some 35 million citizens, 14 percent of the entire population, have no coverage, and the number is rapidly rising. Unless we do something about this problem, we will become a Nation of sick people, unable to produce and help the economy to grow. The linkage between health care and economic recovery is clear and, it is grounded in more than just dollars.

We must begin now to contain health care costs, to make long-term care affordable, to make a way for every person in need to be able to pay for medication and to provide health care coverage for all. Of these goals, cost containment is paramount. If we can not contain costs, we can not have affordable health care and medication for all. More importantly, if we can not contain costs, we can not reasonably expect to have a deficit reduction program.

Mr. Chairman, I cannot close my remarks without recounting a situation which brought this issue dramatically to my attention. Last spring, reading the Philadelphia Inquirer, I noticed an article about a seven month old baby girl in need of a liver transplant. The family could not afford the operation. The operation was a very delicate one that could only be performed in specialized areas. After reading

the article, I was contacted and asked if I could assist in helping this child and her family. I immediately called the Commissioner of Health in Philadelphia, and together with other city officials, we arranged to have the child flown to Boston for the operation. Unfortunately, during our search for transportation, the baby became ill and died before the operation could be performed. Here was an innocent life, not just a number, but a human being, whose untimely death occured only because this Nation currently lacks the resolve and the program to care for all of the sick, when needed. I look forward to this hearing as the beginning of a commitment by the Congress to join with the President in designing a system that provides health care for all. That, it seems to me, is fundamental.

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